DOCUMENT RESUME

ED 339 902 CE 059 862

AUTHOR	Perlman, Leonard G., Ed.; Hansen, Carl E., Ed.
TITLE	Aging, Disability, and the Nation's Productivity. A Report on the Mary E. Switzer Memorial Seminar (15th, Washington, D.C., June 3-5, 1991).
INSTITUTION	National Rehabilitation Association, Reston, VA.
PUB DATE	Oct 91
NOTE	89p.
AVAILABLE FROM	Switzer Memorial Fund, National Rehabilitation Association, 1910 Association Drive, Suite 205, Reston, VA 22091 ($10.00).
PUB TYPE	Collected Works - Conference Proceedings (021)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	Age Discrimination; *Aging (Individuals); *Disabilities; Employer Employee Relationship; *Employment; Employment Practices; Employment Problems; *Equal Opportunities (Jobs); Federal Legislation; *Labor Force; Older Adults; Unemployment; Unions; *Vocational Rehabilitation
IDENTIFIERS	*Older Workers

ABSTRACT

This monograph contains proceedings of a seminar focusing on the enhancement of the lives and independence of older Americans with disabilities. Introductory materials include: an Introduction (Leonard Perlman, Carl Hansen); Seminar Greeting (Richard Materson); Welcome (Harry Smith, Martin Sicker); a foreword, "Meeting the Changing Needs of an Aging America" (Edward Roybal); and a speech by a U.S. Department of Education commissioner, "Aging and Rehabilitation" (Nell Carney). The action papers that served as the basis for deliberations are as follows: "Employment of the Older Worker with a Disability: An Overview" (Kathy Sisco); "Serving the Older Worker with a Disability: The Role of Rehabilitation" (Jerold Bozarth); "Employment of Older Workers with a Disability: Attitudes and Legal Issues" (Malcolm Morrison); "Toward Employer Flexibility through the Employee Life Cycle: The Case for the Older Worker" (Paul Rupert); and "Empire Strikes Back: Meeting the Health Care Needs of an Aging Workforce" (Steven Leclair). Each paper concludes with excerpts of reviews and comments made by Switzer Scholars. The chapters followed by "One Point of View: A Reaction to the Chapters" (Paul Leung) and seven special invited papers: "Aging with a Disability: Another Advocacy Priority" (June Kailes); "Older Workers with Disabilities: A Minority Perspective" (Paul Leung); "Aging, Habilitation, and Persons with Developmental Disabilities" (Richard Coelho); "A Tri-Center Approach to a Unique Dichotomy" (Spencer Bartley); "Wanted for Work: Mature Employees" (Samuel Sacco); "Older and Younger Workers with Disabilities: Shared Needs and Disjointed Policies" (Katherine Seelman); and "Union-Management Cooperation for Implementing the ADA" (Guy Stubblefield). Finally, the major recommendations and implications for action, as developed by the Switzer Scholars, are noted by category for ease of usage. (YLB)

ED339902

Aging, Disability and the Nation's Productivity

A Report on the 15th Mary E. Switzer Memorial Seminar

October 1991

Edited by Leonard G. Perlman and Carl E. Hansen

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

D Weiss

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

LE059 F62

National Rehabilitation Association
1910 Association Drive, Suite 205
Reston, Virginia 22091

BEST COPY AVAILABLE

Appreciation

A Memorial Tribute to James Francis Garrett, Ph.D.

1916-1991

Because the Mary Switzer Memorial Seminar Monographs serve to chronicle, to some degree, the history and changes in the field of rehabilitation, it is also important to take note of special people who have helped to develop this field with their unique contributions. James F. Garrett was one of these individuals who worked for Mary Switzer for over two decades. While Ms. Switzer was the driving force that brought rehabilitation into the mainstream of the federal government, Dr. Garrett provided the vision and developed the framework for rehabilitation research and training that currently exists both in this nation and overseas.

The following is a brief history of Dr. James F. Garrett:

He spent the majority of his illustrious career in the federal civil service, fostering multidisciplinary research and training programs in vocational rehabilitation. He worked at the latter part of his career and at the earlier years in universities and private non-profit organizations, targeting populations whose needs were particularly acute. His influence was felt in the United States and abroad, and his main legacy was programs for professional training, research and service delivery that assisted persons with disabilities to live more independently.

Dr. Garrett served with the U.S. Department of Health, Education and Welfare in increasingly responsible positions between 1951 and 1978. He provided the direction to research, training, and demonstration programs, thereby developing the infrastructure that supports vocational rehabilitation in the United States. He also created an institutional framework that fostered the exchange of experiences across international boundaries. This allowed U.S. practitioners and patients to gain access to technologies and methods developed abroad, and those from other countries benefitted from U.S. scholarships and practice in the U.S. Dr. Garrett retired from the federal service in 1978 as the Executive Director of Research and Evaluation in the Rehabilitation Services Administration (U.S. Department of Health, Education and Welfare).

Dr. Garrett initially came to Washington, D.C. to work for the Veterans Administration where he was influential in developing a comprehensive, multi-disciplinary approach to treating the whole person who experienced a disabling condition. This came at a time when a large number of veterans were disabled by World War II. Prior to entering the civil service Dr. Garrett was affiliated with the International Center for the Disabled in New York City. He was a member of the faculty of the College of Medicine at New York University and affiliated with the Institute of Physical Medicine and Rehabilitation, which later became the Rusk Institute for Rehabilitation Medicine at New York University.

Upon his retirement from the federal civil service in 1978, Dr. Garrett served as Executive Vice President of the World Rehabilitation Fund (WRF) in New York City, and Clinical Professor of Rehabilitation Medicine at the New York University Medical Center. At WRF, he designed programs to train professionals, conduct needs assessments, and provide technical assistance and direct service delivery to countries soliciting the collaboration of the WRF.

Dr. Garrett survived the polio epidemic of 1916 despite six months of complete paralysis during infancy. He was educated in New York City at Regis High School (1933), Fordham University (B.A. 1937; M.A. 1938), and New York University (Ph.D. in Psychology, 1941).

Dr. Garrett has been recognized for his numerous achievements from agencies and organizations from the U.S. and abroad. Some of his awards included the Albert and Mary Lasker Award of the International Society for the Rehabilitation of Disabled Persons, The Howard Rusk Award for Outstanding Contributions to the Field of Physical Medicine and the GEICO Award for the Retired Federal Employee of the Year. The last tribute to Dr. Garrett came on April 5, 1991 from the National Rehabilitation Association for his distinguished work in research effecting persons with disabilities in the U.S. and internationally.

He is survived by his wife, Marie C. Garrett, three children and four grandchildren.

James F. Garrett, a legend in the field of rehabilitation will long be remembered for his many talents and tireless efforts to bring together widely divergent groups and thinkers for a common goal: serving persons with disabilities in pursuit of independence. He was a consensus builder who cared about people, who had a strong sense of purpose and commitment and who was an inspiration to all who had the opportunity to work closely with him. He has effected the lives of countless persons with disabilities and their families and has left a legacy of caring, leadership, sensitivity and achievement that had become his hallmark.

A Scholarship Fund for Students with Disabilities has been established in his honor at his alma mater, Regis High School in New York City.

BEST COPY AVAILABLE

Aging, Disability and the Nation's Productivity

Introduction Leonard G. Perlman and Carl E. Hansen 2
Seminar Greeting Richard S. Materson 4
Welcome Harry R. Smith and Martin Sicker 5
Seminar Sponsors 6
Foreword Congressman Edward R. Roybal 7
The 1991 Switzer Scholars 8
Aging and Rehabilitation Nell C. Carney 10

Chapters

Employment of the Older Worker with a Disability: An Overview Kathy Sisco 11
Serving the Older Worker with a Disability: The Role of *Re*habilitation Jerold D. Bozarth 18
Employment of Older Workers with a Disability: Attitudes and Legal Issues Malcolm H. Morrison 27
Toward Employer Flexibility Through the Employee Life Cycle: The Case for the Older Worker Paul E. Rupert 37
Empire Strikes Back: Meeting the Health Care Needs of an Aging Workforce Steven W. Leclair 44

Special Invited Papers

Aging with a Disability: Another Advocacy Priority June Isaacson Kailes 56
Older Workers with Disabilities: A Minority Perspective Paul Leung 59
Aging, Habilitation, and Persons with Developmental Disabilities Richard J. Coelho 62
A Tri-Center Approach to a Unique Dichotomy Spencer Bartley 64
Wanted for Work: Mature Employees Samuel R. Sacco 66
Older and Younger Workers with Disabilities: Shared Needs and Disjointed Policies Katherine D. Seelman 68
Union-Management Cooperation for Implementing the ADA Guy Stubblefield 71

One Point of View: A Reaction to the Chapters Paul Leung 55
Seminar Recommendations 75

Copyright 1991. Reproduction permitted without permission. Give credit to the National Rehabilitation Association and send a copy to the Association office.

National Rehabilitation Association
1910 Association Drive
Suite 205
Reston, Virginia 22091
VOICE (703) 715-9090
TDD (703) 715-9209
FAX (703) 715-1058

Editors
Leonard G. Perlman
Carl E. Hansen

Managing Editor
Mark W. Doyon

1991 Switzer Scholars
Spencer Bartley
Laurel Beedon
Richard Blake
James E. Bordieri
Jerold Bozarth
Judy Ann Buffmire
Richard Coelho
Thomas J. Fleming
June Isaacson Kailes
Steven Leclair
Paul Leung
J. Elton Moore
Malcolm Morrison
John R. Nelson
Richard P. Oestreich
Paul E. Rupert
Betty Sayer
Katherine D. Seelman
Kathy Sisco
Susan Jay Spungin
Guy Stubblefield
Linda Workman

The *Switzer Monograph* reflects the writings, discussions and recommendations of the Switzer Scholars at the 15th Annual Mary Switzer Memorial Seminar, held June 3-5, 1991, at the National Rehabilitation Hospital in Washington, D.C. Opinions expressed in the *Switzer Monograph* are those of the writers and do not necessarily reflect policy of the National Rehabilitation Association or any other organization.

The National Rehabilitation Association is a non-profit organization dedicated to improving the quality of life for people with disabilities.

Published October 1991. To order previous editions of the *Switzer Monograph*, contact the National Rehabilitation Association at (703) 715-9090.

BEST COPY AVAILABLE

Introduction

Leonard G. Perlman

Carl E. Hansen

It was coincidental that while the Switzer Scholars were developing final recommendations as a result of the deliberations, another group of people were rallying just two miles away at the United States Capitol. The latter group of about 6,000 older Americans gathered to urge the federal government to provide more services for the nation's growing population of older people. Another major purpose was to show that older Americans could be a national resource rather than a national problem. It is this latter point upon which the 15th Annual Mary Switzer Memorial Seminar focused.

In 1986, the topic of the Memorial Seminar was, "The Aging Workforce: Implications for Rehabilitation," which was hosted by the American Association of Retired Persons (AARP). The proceedings of that Seminar provided the impetus and stimulation for action in this important, but often neglected area of concern. The 15th Switzer Memorial Seminar updates the earlier findings and takes a fresh look at important new concepts and ideas as we prepare for the 21st century.

The Switzer Memorial Seminars

These special Seminars are named for the late Mary E. Switzer, America's foremost leader and trailblazer for innovative programs at the national, state, and local levels for people with disabilities. For more than thirty years, her influence was felt in the area of vocational rehabilitation as head of the Rehabilitation Services Administration and the Social and Rehabilitation Services of the (then) Department of Health, Education and Welfare.

The Switzer Memorial Committee was started by her colleagues and friends, including key members of the Congress, Secretaries of the U.S. Department of Health, Education and Welfare and the Department of Labor, and private citizens interested in rehabilitation of people with disabilities. The Committee is administered by the National Rehabilitation Association (NRA).

Carl E. Hansen, Ed.D.
Switzer Committee Chairperson

Purpose of the Memorial Seminars

The Seminar is designed to bring together a small number of experts (18 to 20) in the area of rehabilitation that is the focus of each year's Seminar. The experts serving the betterment of persons with disabilities are designated as Switzer Scholars by certificate, and this recognition has become a significant and prestigious achievement for those interested in vocational rehabilitation, both nationally and internationally. The product of the three-day Seminar is a published Monograph of the proceedings, including recommendations for future programming, research, training, and legislative needs. The format is designed for use by counselors, consumers, researchers, employers, educators, and policy makers, or anyone interested in the rehabilitation of persons with disabilities.

The Current Seminar

The 15th Mary Switzer Memorial Seminar was held in Washington, DC from June 3 to 5, 1991 and was hosted by the National Rehabilitation Hospital (NRH). The focus of the Memorial Seminar was, "Aging, Disability, and the Nation's Productivity."

Welcomes were provided by Richard S. Materson, M.D., Vice President for Medical Affairs and Medical Director, NRH, and Jan Galvin, Director, Rehabilitation Engineering Center of the NRH, and Dr. Martin Sicker, Director, Worker Equity Department, American Association of Retired Persons (AARP).

Dr. Carl E. Hansen provided welcomes in behalf of Harry Smith, NRA President and Dr. Robert E. Brabham, Executive Director of NRA.

The Honorable Nell C. Carney, U.S. Commissioner, Rehabilitation Services Administration (RSA), helped to set the tone and direction of the three-day program with a moving keynote address. In her remarks, Ms. Carney stated that, "Working with older Americans with disabilities offers a unique opportunity for expansion of our vocational rehabilitation and independent living (IL) programs.

At the same time we can make significant contributions to the Nation's economy and enrich community life with the inclusion of older Americans."

Planning for the Seminar

The Switzer Planning Committee developed the objectives of the Seminar and provided the format and subtopics to serve as a foundation for the Seminar. These subtopics were translated into action papers and served as the basis for the deliberations that have become the hallmark of the Switzer Memorial Seminars. The action papers and their authors were as follows:

- *Employment of the Older Worker with a Disability: An Overview*, by Kathy Sisco, Aging in America, Inc.
- *The Role of Rehabilitation: Serving the Worker with a Disability*, by Jerold D. Bozarth, University of Georgia at Athens.
- *Toward Employer Flexibility Through the Employee Life Cycle: The Case for the Older Worker*, by Paul E. Rupert, New Ways to Work, Inc.
- *Meeting the Health Care Needs of an Aging Workforce: Empire Strikes Back!*, by Steven W. Leclair, National Industrial Rehabilitation Corp.
- *Attitudes and Legal Issues: The Older Worker with a Disability*, by Malcolm H. Morrison, National Association of Rehabilitation Facilities.

The above action papers and the discussions covered a broad range of challenges, ideas, and recommendations. In addition, the Seminar stimulated a number of special papers such as: *Aging with a Disability (A Consumer's Point of View); A Minority Point-of-View as it Applies to Older Workers; Applications to the Americans with Disabilities Act (ADA); Aging, Habilitation and Persons with Developmental Disabilities; Labor Union Issues and the Older Worker;* and *Opportunities for the Mature Worker in the Part-Time and Temporary Job Market as a Viable Alternative.*

The deliberations also focused on such items as trends in the United States' economy, impact of the global economy, the changing nature of the workforce, models of employment, retraining and transfer of skills.

Leonard G. Perlman, Ed.D.
Switzer Seminar Coordinator

Format of the Switzer Monograph

The Seminar brought together some of the best minds in the areas of aging from around the United States, with views from consumers, industry, labor, and the rehabilitation professions. Their combined ideas and recommendations are presented in this text. In addition to five chapters, each chapter is followed by excerpts of reviews and comments made by the Switzer Scholars. These sections provide a variety of perspectives from participants who represented a broad cross-section of professional disciplines, consumers, business, and labor. The chapters are followed by seven special invited papers with a variety of viewpoints regarding the central theme of the Seminar. Finally, the major recommendations and implications for action, as developed by the Switzer Scholars, are noted by category for ease of usage.

Considerable effort by many persons has gone into the development of this *Switzer Monograph*. It is the hope of the Switzer Scholars and the Switzer Memorial Committee that this text will stimulate communications, strategies, and positive action by all necessary partners to enhance the lives and independence of older Americans with disabilities.

Seminar Greeting

Richard S. Materson

The return of the Mary Switzer Memorial Seminar to National Rehabilitation Hospital is a great pleasure for us. The joy of greeting old friends and colleagues from the rehabilitation community and the privilege of greeting those of you new to us are welcome feelings. Of course we are specially honored to have RSA Commissioner The Honorable Nell Carney back with us at National Rehabilitation Hospital. We are eager to hear her remarks.

Those of us who had the great pleasure of working with or knowing Mary Switzer know how much our lives were touched by her unparalleled leadership and singleness of purpose, hope that all of us will be inspired by our remembering her priorities as a champion of the nation's disabled and will be inspired towards even greater creativity and efforts as we set about our tasks here.

How fitting that this Seminar is cosponsored by the American Association of Retired Persons, that prestigious group so well known for its leadership and championing the cause of those who have had fifty years of life's experiences behind them. Their participation in "Aging, Disability and the Nation's Productivity" is further testimony of AARP's interest in enhancing quality of life.

Too often those of us in medical rehabilitation have allowed knee jerk reflex rejection of vocational rehabilitation and other services for our patients in their late fifties and early sixties and beyond. We don't see investment in significant services for this population as a wise use of funds because the retiree stereotype is so unrepressed. Yet a look at the portrait photographs on the wall outside this board room will give a quick jolt to those who think the over '60s are done as contributors to society.

Take, for example our founding Chairman of the Board and current Vice Chair, The Honorable Stephen Ailes. Now nearly 80, this former Undersecretary then Secretary of the Army, member of the President's Foreign Intelligence Advisory Board and Intelligence Oversight Committee, and veteran of numerous highly responsible government boards and agencies, was also President and CEO of the Association of American Railroads. He has had a long and productive practice with his law firm Steptoe and Johnson and was a Director of Riggs National Bank. But aside from his monumental help in getting this rehabilitation hospital up and going, also serves and was trustee for the Maryland Chapter Nature Conservancy, is Trustee Emeritus of Princeton University, Emeritus Trustee and former President of the Board Episcopal High School, Emeritus Trustee Federal City Council, and former Board Chairman of the Greater Washington Telecommunications Association, Inc., among other civic contributions. And he is an avid farmer, fisherman and golfer! Slowed down? Hardly!

Or Vice Chairman, The Honorable W. Graham Claytor, Jr. who at 79 is Chairman and President of the National Railroad Passenger Corporation. Mr Claytor says he'll retire from AMTRAK when it's showing a profit. A past Secretary of the Navy, Trustee of the Committee for Economic Development, he is an astute and key advisor to our hospital keeping those of us in administration on our toes. But he also has time to be a Trustee of the Eisenhower Exchange Fellowships, Inc. Can't call him past vocation, can we?

Take the further example of our current Chairman of the Board The Honorable James W. Symington, a former Member of Congress from Missouri, former U.S. Chief of Protocol, former Deputy Director of the Food for Peace Program and Chairman of the Fund for the Improvement of Post-Secondary Education, besides his active law practice finds the time for voluntary civic contributions as a Trustee of St. Stephens School, Member and Former Chairman of the Foreign Student Service Council, the Washington Performing Arts Society, the Washington National Monument Society, the Wadsworth Foundation and others. If that were not enough, his Civil War history penchant made him a contributor to WETA's acclaimed Civil War Docudrama. He conducts this Board as a seasoned conductor would an orchestra getting the utmost from every contributor. And he's an outstanding pianist and barbershop quartet anchor to boot! Any youngsters want to take on that record?

The curriculum vitae of our other AARP eligible Board members is equally impressive. Thomas Parrott, Vincent Burke, Ward Chamberlin,Jr., The Honorable Tony Coelho, Dr. Bob Collins, recently deceased but revered Dr. Clinton Compere, Dean Charlie Epps, Norman Farquhar, ViCurtis Hinton, Ed Mitchell, Monsignor Murray, The Honorable Paul Rogers, Leonard P. Steuart and James Holleran are pictured representing vigorous active socially committed continuing contributors to society through vocation and avocation. And they are but a microcosm of the valuable contributions and activity of "elder" persons throughout this nation and the world.

This makes the theme for this conference so very important. We must have the insights to prevent that disability which can be prevented, to assure moderation in lifestyle to maintain long life and good health, to apply the best medicine has to offer when illness or injury does strike, to prevent secondary disability by strict attention to detail, and to provide enthusiastic cost effective rehabilitation services to return these very important contributors to their proper level of self care and productivity at home and in society.

So I challenge you to take Mike Vance's theme and think "outside of the box" avoiding age linked stereotypes as you forge ahead with review, analysis and addition to the papers that have been prepared for you.

You have been selected to join a prestigious group as Switzer scholars. Congratulations to each of you. Godspeed in your work.

RICHARD S. MATERSON, M.D., is Medical Director, National Rehabilitation Hospital, Washington, D.C.

Welcome

Harry R. Smith
President
National Rehabilitation Association

The topic for this year's Mary Switzer seminar is especially timely. This monograph signifies the third time in a decade that the National Rehabilitation Association has focused upon issues of Aging, Disability and Rehabilitation. A special issue of the *Journal of Rehabilitation* (Oct.-Dec. 1981) was entirely devoted to the rehabilitation of older individuals. In 1989 the editor of the *Journal* committed both the cover and feature space to the subject of Aging and Disability.

With this monograph, NRA continues to foster examination of an important social issue. Serious inquiries are also now being conducted by other scholars and researchers.

The parallel work reported by the Institute on Rehabilitation Issues and the Institute of Medicine on the same general topic in no way detracts from this year's Switzer Scholars. From my vantage point, NRA may have begun the examination of Aging and Rehabilitation in 1981. Others have now joined in the endeavor.

To all who were involved with this monograph, please accept my appreciation for your endeavors and support.

Martin Sicker
Director
Worker Equity Department, AARP

The theme of this year's Switzer Seminar, "Aging, Disability and the Nation's Productivity," could not be more timely or appropriate. Our society is being challenged by a continuing decline in national productivity at the same time that it must strive for a satisfactory position in an increasingly competitive global economy. One of the key factors determining our productivity and competitiveness is the quality of the American work force, which has become a matter of growing national concern. The problems of literacy in the work place, technological competence and an appropriate work ethic are endemic and demand a significant societal response. Yet, as government and business attempt to deal with these challenges and concerns, very little attention is being paid to how the considerable human resource assets represented by older and disabled workers might be mobilized in support of such efforts. This seminar will surely provide valuable insights on how the skills, experience and stability of older and disabled workers can contribute to improving national productivity and competitiveness, and, thereby, to the general welfare of our society.

Acknowledgements

The 15th Mary E. Switzer Memorial Seminar and Monograph of the Proceedings were made possible by a number of people and organizations committed to the independence and employment of persons with disabilities.

Thanks to: The Switzer Memorial Committee of the National Rehabilitation Association (NRA); Harry R. Smith, NRA President; Robert E. Brabham (then Executive Director of NRA) and staff; Mark W. Doyon, NRA Communications Director; and the Planning Committee for the 15th Switzer Memorial Seminar.

Our special thanks to the National Rehabilitation Hospital, the host organization, for providing the excellent setting for the Switzer Scholars for the third year. The following persons are recognized: Edward A. Eckenhoff, President, Richard S. Materson, M.D., Vice-President for Medical Affairs and Medical Director, Jan Galvin, Director, Rehabilitation Engineering Center, and Alica Johns and Dalevonne Davis of the Center.

Gratitude is expressed to Dr. Martin Sicker, Director, Worker Equity Department of AARP and Bernard Nash of AARP for their guidance and support throughout the process from conception to implementation of the Seminar.

Appreciation is extended to all of the sponsors who helped to make the 15th Seminar and the Monograph a reality through their generosity.

Finally, our thanks to the Switzer Scholars for giving so freely of their time and talents and whose ideas and recommendations are presented in this monograph. They have our congratulations and admiration.

Photographs by David Kasamatsu.

The Sponsors of the 15th Mary Switzer Memorial Seminar and Monograph

The support of the following sponsors is deeply appreciated.

American Association of Retired Persons (AARP)
Washington, D.C.

The Dole Foundation for Persons with Disabilities
Washington, D.C.

E.I. duPont de Nemours and Company
Wilmington, Delaware

Electronic Industries Foundation
Washington, D.C.

Human Resources Center
Albertson, New York

National Rehabilitation Counseling Association
Reston, Virginia

National Rehabilitation Hospital
Washington, D.C.

Powers Coalition, Inc.
Washington, D.C.

President's Committee on Employment of People with Disabilities
Washington, D.C.

World Rehabilitation Fund
New York, New York

Dr. Carl E. Hansen, Past President, NRA
Austin, Texas

Foreword

Meeting the Changing Needs of an Aging America

Congressman Edward R. Roybal

Mary E. Switzer's life and work on behalf of disabled individuals have served as an inspiration to many of us who have sought to enhance the quality of life for all of our nation's residents. Commemorating and carrying on her efforts, the 15th Annual Switzer Seminar has provided a forum for the analysis and discussion of an issue that lies at the heart of the country's ability to prosper— making full use of its human talent and potential. Because of its timeliness and value, I am honored to have the opportunity to introduce the reader to the monograph on "Aging, Disability, and the Nation's Productivity."

As the median age of our population continues to increase, it becomes incumbent upon decision-makers to develop sufficient opportunities for older individuals wishing to remain active in the work world. We also know the American workplace is changing rapidly at a time when the nation's ability to compete in the international arena is increasingly threatened. Against this backdrop, we are indeed fortunate to have at our disposal the recommendations presented by the Switzer scholars at this recent seminar. Their insightful approach can provide a framework for legislators, employers, and other professionals who are already looking for alternatives to their current mode of operation.

We have already made significant progress towards accommodating the needs of disabled individuals and have, therefore, begun to tap this great human resource. Older workers have likewise enjoyed increasing protections under the law and improved access to a social safety net that is the legacy of individuals like Mary Switzer. As we now look ahead to the full implementation of the most recent initiative to benefit the disabled and older worker, the Americans with Disabilities Act (ADA), we in Congress can take a modicum of pride in this most recent legislative accomplishment but must remain vigilant to ensure that its intent is carried out.

As the regulations governing ADA's implementation become effective, employers looking to comply with the new federal requirements will be seeking guidance from rehabilitation professionals. This legal climate provides an opportunity for the issues and concerns raised in the Switzer Seminar to be considered.

In this vein, I want to express my sincerest appreciation for the contribution made by the Switzer Seminar series on Vocational Rehabilitation. I would urge that the issues and recommendations raised here be fully explored and considered by the broadest public, knowing that benefits bestowed upon the disabled and older worker readily spill over into every other sector of society.

EDWARD R. ROYBAL is Chairman of the Select Committee on Aging, U.S. House of Representatives.

1991 Switzer Scholars

Spencer Bartley
Southland Corporation
Alexandria, Virginia

Laurel Beedon
AARP Public Policy Insititute
Washington, D.C.

Richard Blake
University of Nebraska
Omaha, Nebraska

James E. Bordieri
Southern Illinois University
Carbondale, Illinois

Jerold Bozarth
University of Georgia
Athens, Georgia

Judy Ann Buffmire
Utah State Office of
Rehabilitation
Salt Lake City, Utah

Richard Coelho
National Rehabilitation
Counseling Association
Lansing, Michigan

Thomas J. Fleming
AIREE
Fairfax, Virginia

June Isaacson Kailes
Consultant
Playa Del Rey, California

Steven Leclair
National Industrial
Rehabilitation Corporation
Worthington, Ohio

Paul Leung
University of Illinois
Champaign, Illinois

J. Elton Moore
Mississippi State University
Mississippi State, Mississippi

BEST COPY AVAILABLE

John R. Nelson
Rehabilitation Services Administration
Washington, D.C.

Richard P. Oestreich
Vision Center of Central Ohio
Columbus, Ohio

Paul E. Rupert
New Ways to Work
San Francisco, California

Betty C. Sayer
American Association of Retired Persons
Gouldsboro, Pennsylvania

Kathy Sisco
Aging in America, Inc.
Bronx, New York

Susan Jay Spungin
American Foundation for the Blind
New York, New York

Guy Stubblefield
IAM CARES
Washington, D.C.

Linda I. Workman
RJR Nabisco, Inc.
New York, New York

Not pictured...

Malcolm Morrison, National Association of Rehabilitation Facilities, Washington, D.C.
Katherine D. Seelman, National Council on Disability, Washington, D.C.

15th Mary E. Switzer Memorial Seminar Planning Committee

Laurel Beedon, American Association of Retired Persons (AARP)
Joan Kelly, AARP
Martin Sicker, AARP
Bernard Nash, AARP
Richard Drach, E.I. duPont
Thomas J. Fleming, American Institute of Rehabilitation, Education and Employment
Ralph N. Pacinelli, Rehabilitation Services Administration (RSA)

BEST COPY AVAILABLE

Aging and Rehabilitation

Nell C. Carney

It is a real pleasure to be back for the second year to talk with the Switzer Scholars about rehabilitation. This year you will be considering rehabilitation services for older Americans with disabilities, a topic truly worthy of the amount of attention it will receive here.

By the year 1996, it is predicted there will be 34 million Americans over the age of 65. Of this number, a significant percentage will have disabilities. There will be two groups of seniors with disabilities, one made up of people who have been disabled for a period of time and are now aging, and another group of people who have reached senior citizen status and then acquired a disability. There may even be a third group — people who have been disabled for a period of time and acquire an additional disability after reaching senior citizen status.

Whether older Americans should be provided Vocational Rehabilitation services is not an issue. Of course, this population is appropriate for vocational and other rehabilitation services including independent living (IL). Using the same individualized approach that is traditional with the provision of rehabilitation services in the State/Federal VR program, the evaluation, training and placement needs of older Americans with disabilities can be met through existing agencies.

Additionally, the independent living programs of Title VII (Rehabilitation Act) including Part A IL services through state VR agencies, Part B IL Centers, and Part C programs serving older blind persons are tremendous resources for this special population. Community access, social and recreational involvement, and the opportunity to live independently in the community are just a sampling of the benefits of participation in independent living services.

Current predictions for the labor market by the year 2000 indicate there will be many more jobs than qualified workers during this decade and on into the next century. The population of older Americans, therefore, becomes an important resource for recruiting qualified and motivated workers. There is no question that older workers trained by VR agencies will have a major, positive impact on the labor force in the next two decades and beyond.

Rehabilitation services for this population will not create significant financial strain on existing delivery systems. As a group, this population has access to significant comparable benefits including Medicare that will contribute toward meeting the costs of physical restoration, placement and other services.

There are, also, other funding sources that may contribute to the rehabilitation of older Americans with disabilities. For example, all states now have special funding for the "aging population." State lotteries underwrite costs of certain services. As the population of older Americans with disabilities grows, so do the networks for aging. Close coordination of services can result in increased benefits for these individuals.

A number of studies indicate about forty percent of the retired population would like to return to work. Many would like to supplement retirement benefits, and others would like to become more active in the workplace and community. Our rehabilitation programs offer the gateway for such achievement by the seniors of this country.

The inclusion of technology into every facet of public and private employment creates a new challenge for the involvement of vocational rehabilitation services to older Americans with disabilities. Retraining to the new technical age is an appropriate goal for potential workers of any age.

Three Research and Training Centers funded by the National Institute on Disability and Rehabilitation Research are conducting valuable research on the provision of rehabilitation services for older Americans with disabilities. For example, the Research and Training Center for Rehabilitation of Elderly Disabled Individuals at the University of Pennsylvania in Philadelphia is demonstrating the efficacy of a coordinated and comprehensive approach to restoring, preserving and enhancing the older person's ability to function productively and independently. Other studies contribute to the pool of knowledge and experience essential for the development of public policy and the designing of responsive and relevant delivery systems and services.

The provisions of the Americans with Disabilities Act are, of course, applicable to older Americans with disabilities in the prohibition of discrimination on the basis of disability. This civil rights protection together with the protection of laws that prohibit discrimination on the basis of age provide enhancement for training and placing older people with disabilities.

Working with older Americans with disabilities offers a unique opportunity for expansion of our vocational rehabilitation and independent living programs. At the same time we can make significant contributions to the nation's economy and enrich community life with the inclusion of older Americans.

If Mary E. Switzer were here today, she would endorse the opportunity to provide services to this very special population of Americans. Her propensity for visionary leadership brought new energy and insight to addressing the challenges presented by meeting the rehabilitation needs of unserved and underserved populations. She would have applauded the importance that you are placing on the issues under study at this seminar. Since she can't be here, I am proud to stand in her place and to charge you in preparation for the important work that you will perform over the next several days. What you produce here will be used by the rehabilitation and related fields for years to come. I wish each of you a personally satisfying and professionally productive experience.

NELL C. CARNEY is Commissioner, Rehabilitation Services Administration, U.S. Department of Education.

Chapter One

Employment of the Older Worker with a Disability: An Overview

Kathy Sisco

This paper provides an overview of work, disability, and the older person. Demographics and surrounding issues are briefly discussed followed by an examination of the local marketplace and the global economy. The relationships between business needs and job candidate needs are explored. Some exemplary model programs and resources are described. Factors important to successful work with this population are also outlined. A theme throughout is need for education.

Regardless of age or position, employment often enables people with disabilities the opportunity to achieve to their full potential. While not the only option, work often enhances a sense of self-esteem, provides structure, creates social opportunities, offers financial gain, provides self-respect and dignity. When an individual wishes to work but is not able to do so, the individual's self-concept might be significantly altered. The topic of employment of the older worker with a disability is timely because there are both obstacles and opportunities for this population to achieve and contribute.

Aging

While many of us are concerned when we think of our own aging, it is merely a natural process that begins at birth and ends with death. The definition of old is relative to the person who is discussing "old age." If you talk to a 15 year old, 25 might be considered "old." As we grow older, our image of old usually grows many years beyond our own chronological age. The Americans with Disabilities Act (ADA) considers a worker "older" at age 40, which may come as a shock to persons approaching this chronological milestone.

Job Training Partnership Act (JTPA) uses age 55 to denote an older worker. Community based programs that serve people who are older have age ranges from age 45 through 60 and up. Social Security Retirement benefits can begin as early as 60 for widows. Prior to ADA, the mandatory retirement was at age 70. The simple truth is everyone ages but there is no single definition that fits everyone exactly.

KATHY SISCO is Director, Employment Services, Aging in America, Inc., Bronx, New York.

The Demographics

We do know that in the United States, life expectancy is increasing. At present, a 65-year-old person can expect to live another 17 years. According to the 1989 Bureau of Labor Statistics, in 1986 there were 74.2 million citizens age 45 and older. It is projected by the year 2000 there will be 96.3 million people aged 45, and people 65 and over will comprise 13% of the nation's population.

In 1987, the United States Department of Labor reported there were 7.4 million unemployed. Of those, 1.2 million jobless were over the age of 45. According to the American Association of Retired Persons (AARP), 40% of retirees would prefer working but are not working for a variety of reasons. These retirees would fit into a group known as discouraged workers. Discouraged workers are hard to capture in national unemployment statistics because they are not actively seeking work.

Disability

At this time, approximately sixty percent of the population with disabilities in the United States is 45 years of age or older. As far back as June 1985, the Social Security Administration reported that there were nearly 2.7 million persons collecting Social Security Disability Insurance (SSDI) benefits, 68% of whom were over the age of 50. Because the 45 and older age group is increasing, there will be more people with disabilities than ever before. While the 45+ age group makes up the largest percentage of Social Security Disability Insurance recipients, services to assist this population are in short supply. It is also important to examine how vocational rehabilitation services can be expanded to serve this growing population.

Older Population

Two facts stand out: 1) older people will need the financial support of work; 2) the economy will need them because growth of the workforce is slowing. Before the full effect of the aging of our population is felt, it is important that policy makers,

legislators, employers, and older workers look at ways to plan and assure this valuable resource of older, disabled workers is not wasted.

Unemployment Issues

There are over a million older Americans (with and without disabilities) not yet retired who are jobless. The 1986 current population survey showed that these older, displaced workers were less likely to become re-employed and far more likely to be out of the labor force than were their younger counterparts as noted by Rones and Herz (1989). In addition, this 1989 Labor Market Report stated that job seekers in their late fifties and early sixties who are now jobless and who are intending to return to work, often do not have the resources to support themselves. Research shows that once out of the labor force, older workers experience greater difficulty than the young workers in returning.

Poverty

In addition to high unemployment numbers, over 20% of older Americans are near or below the nation's poverty level (Janicki, Anderson, and Harward, 1990). The dual problems of poverty and unemployment are happening at a time when there are great demographic shifts in the current labor force. The demographic shifts are further complicated by a shortage of skilled labor and influx of workers who lack specific skills and education necessary to meet employer demands.

Workforce Demographics

In addition to age, other demographic changes include the large numbers of women and immigrants in the labor force. It is estimated by the year 2000, 80% of the net growth in the labor force will come from minority youth, women, and immigrants (McLaughlin 1989). According to McLaughlin (1989), women accounted for slightly more than 40% of the displacement of older workers in a 1986 survey. Both women and immigrants,who 20 years ago had limited worker representation, now need to work. They often lack the experience and/or are less educated.

The Workplace

In addition to the unemployment crisis, the American workplace is changing in response to the pressures of the world. In the past 100 years, we have seen America make marked changes from an agricultural-manufacturing society to one of service, technology, and information. The next century will see even more dramatic changes. By the end of the century, an estimated five to 15 million manufacturing jobs will be restructured, an equal number of service jobs will probably become obsolete (Kohlberg, 1986). All these facts reiterate that we must plan for including our richest resource, older manpower, at a time when we need it most. Early departure from the workforce is costly to the individual, employer, and the nation.

Today's workplace is part of a global economy. What may have taken several months to accomplish twenty years ago may occur in seconds now due to high tech advances. In this competitive, high tech arena, cost effectiveness and technical "know-how" are essential. When workers are not given an opportunity to keep pace and do not have the skills, businesses respond by relocating, automating, exporting jobs to other countries, importing foreign workers, and/or augmenting existing workers' responsibilities. The danger of these responses is limited growth in domestic jobs, higher unemployment rates, loss of a reliable domestic workforce, loss of tax paying contributors, higher taxes, and the perpetuation of an unskilled workforce.

An Alternative Workplace

These not so desirable consequences do not have to be the future of American workplaces. Many businesses use options that neither disrupt performance nor negatively influence the bottom line. Some employers are changing their office procedures to accommodate the needs of older workers. Some use individually designed flexible work schedules. Also used is job sharing— two or more part-time workers share one job. Most employers have found job sharing and flex schedules are not burdensome. Some may find these practices improve cost effectiveness for the employer.

Given that not all older workers have similar needs, flexible salary, benefits, and pension packages are also worth the employers' time to explore. Some older workers may be attracted by medical benefits, others by salary, and others by a pension package. There are older workers who would prefer a medical package more than an increasingly responsible position with a higher salary. By the same token, not all older workers are interested in low paying positions. Within legal limits, employers get the personnel they want by offering various plans that fit the needs, preferences, and work responsibilities of the older persons they hire.

Providing education, either on the job or off, is another option for employers to attract older workers. Many businesses offer training programs to their staff regardless of age or disability and find this is a way for the business and individuals to maintain the competitive edge. Informed employees can make informed decisions, furthering the effectiveness of the business.

Here in New York, there are a number of companies that not only train and cross-train worker entrants with job-related training but also, in many cases, offer English as a Second Language to employees. The obvious benefit for the employer is that the worker will understand how to accomplish the project assigned. Training for the older labor force must be designed to meet specific needs and capitalize on strengths. Training may take the form of self-paced tutorials, on-the-job-coaching, or programs designed by and for the older worker. The significant benefit of educational implementation is the return investment to the company from the worker.

Less obvious but of equal value to establishing a solid older workforce are partnerships created between business and the service provider community. These partnerships are becoming more common and have been found to be a practical way to work. Employers see these partnerships as a means to understand the community in which their business resides as well as a mecha-

nism to promote responsible action. These partnerships can make the difference in creating opportunities for and working with the under-utilized resource of older personnel. Many successful community based employment programs and educational initiatives operating today are the result of the community working with business.

A New Older Worker

For a wide variety of reasons, older people today want to work: financial security, social network, structure for the day, new skills, and a feeling of worth. Generally speaking, today's older person does not have more than twelve years of education, but does have many years of work experience. This experience is often at a job that required skills no longer needed in today's workplace. To make a successful return to work, the older worker must be prepared with the skills to secure employment.

What the Older Worker Can Do

Interviews

Upon initiating the job search, the applicant will learn there is an art to interview question response, application completion, and to marketing oneself. Simply requesting an appointment does not guarantee a hire. In fact, requesting an interview requires an etiquette not required years ago. For the new entrant, having these skills will certainly enable him/her to move past the receptionist. It is not uncommon for the older worker to become distressed at the outset without these essential skills. Programs that offer assistance to the older job candidate must prepare the candidate with these remedial skills.

Description of Skills

Older job entrants often learn they are either overqualified for a position or their skills are no longer relevant. Many older workers need assistance in explaining skills that may have value to employers. In addition, older workers often tend to understate behaviors that are valued by employers, such as their longevity within a company, ability to handle varied circumstances, ability to follow instructions, ability to attend to detail. These work behaviors are as important as the technical skills necessary to complete the work function.

If an older person has no work history, then the older person (generally a woman) needs to learn from the service provider how to explain this in terms that are transferable to work skills and a specific job match. This can be accomplished by describing time spent in community activities, raising children, civic responsibilities, PTA meetings, hobbies, or caring for older relatives. Fear of inability to do the job is also quite common. The older worker should be reminded that there is no job where the new employee did not need some type of training.

Training

Skill specific enhancement training as provided by the service provider is another option. Training not only teaches skills, it may also offer the candidate an opportunity to: work within a group; receive instructions from a leader; work on a schedule that permits time for adjustments in personal habits that will be required in a job. The training period is an opportunity for the entrant to review and plan an appropriate dress code, learn how to interact within a business setting and gain confidence. As with any job seeker, the older job seeker needs to be reminded by the service provider to be honest and realistic in establishing vocational goals.

Careful planning and decision making is essential for a successful job placement outcome. This planning can be aided by community service providers. Such assistance has proven useful to the older worker throughout the job application, job matching, and placement process.

Volunteering

If the job candidate can afford it, volunteering is another way for a person to become employed in a setting and climate that is right. Volunteering provides many opportunities: skills can be gained, a social setting can be achieved and; ultimately, a volunteer can become indispensable to the business. While the myth that volunteers are free, is a myth, priceless is often how employers deem these donors of time and effort. It is an exchange of service. The employer will instruct the volunteer on how to achieve the desired results. If at a later date, this volunteer chooses to attain paid employment, he/she can promote this recent experience either within the agency or elsewhere.

Older People with Disabilities

For the older population with disabilities falls dual barriers to employment. However, many in this group, regardless of their age and disability, want and/or need to work and, as the growth of the labor force slows, employers will need this resource. If we as a society are to be successful in meeting the needs of both mature workers and of employers, we must support programs that match the needs of both the employer and the mature job candidate.

Model Programming and Resources

There are many Projects with Industry (PWI) programs funded through the United States Department of Education, Rehabilitation Services Administration (RSA) throughout the nation. Most PWI's do not have age requirements. It is possible to find a local placement resource that specializes in serving persons with disabilities regardless of age. In the near future, however, there will be a minimum of five Projects with Industry designed specifically to meet the needs of the older person with a disability. Sandy DeSantis, former Project Coordinator, described the model as follows: It is composed of three essential elements: a linkage to the private sector, a training site, and a source of people with disabilities.

Aging in America

At the risk of seeming to plug the Aging in America (AIA) and Projects with Industry model, this author will share some of the services deemed necessary for this older population.

Aging in America has an eleven-year history in serving older job candidates with disabilities. Over this time, much has been

learned about this model and how candidates, providers, and employers can benefit.

Aging in America, New York, has a PWI employment program. Its Employment Services is designed after the Projects with Industry model. It offers intake, job matching, job referral, training, and placement services. The Employment Services Department of Aging in America has been guided by its Business Advisory Council to serve all persons regardless of disability. The population comprises of individuals 45 years of age and above. The average age of the persons served is 61 years old. The model includes extensive partnerships with the business community and local service providers.

Job skill enhancement services offered include resume writing, application completion, proper presentation, business education, interview response, and successful candidate marketing. At AIA, two training programs are offered to assist with work re-entry.

A small staff and a large number of business partners place annually more than three hundred persons. This success is based on the interaction between business and referral sources.

Business

In addition to placements, these partnerships have supported many endeavors of this non-profit organization: donation of modern technological equipment; curriculum recommendations for candidate word processing training; education to staff on topics of improved marketing strategies and quality assurance; expansion of incoming membership for the business council; job fair and conference planning visibility by media; and supplemental funds for program continuation, and more.

The business leaders turn to Aging in America for technical assistance. To maintain this support network, technical assistance, educational conferences, and ongoing communication occurs routinely. Meetings are held quarterly with these advisors, and committees are developed as needed for special projects. Recently, AIA held a conference on the Americans with Disabilities Act to share information. This dialogue enabled employers to understand more fully what the law entails.

Community Service

Community service providers are also critical to the success of job candidates served. Often the service providers do not specialize in working with the older worker and turn to us for advice or referral of entering job candidates. It is the policy of Aging in America to work with whoever asks to provide options and opportunities for older workers. In so doing, the AIA Employment Services Department works closely with the community. Rehabilitation and gerontological professionals seldom have reason to work together. In an effort to create more and better services for the older population, AIA serves as a liaison between these groups. A strength of Aging in America is its support of education for all associated and/or served.

Employment

Employers are an excellent resource; however, they too require education. Often it is the community-based provider who has the expert answers. An example of this need for education is businesses' response to candidate applications. Business is experienced in matching people to position but, for the most part, does not have training in rehabilitation options. Some personnel officers feel uncomfortable about asking how the employer could provide assistance to the candidate so he/she could handle the job. Consequently, the applicant may be overlooked because a discussion about accommodation from a referring advocate or from the candidate has not occurred.

The Americans with Disabilities Act allows employers to ask questions about the applicant's ability to perform essential functions of the job. If these questions are not asked, then incorrect assumptions can be made which may jeopardize the most qualified candidate's chance of getting the job.

The National Association of Area Agencies on Aging publication entitled The Directory of State and Area Agencies on Aging is an excellent tool for use when researching local services geared for an aging population. This directory lists each agency, address, and contact person by state. This publication is also a useful tool for the rehabilitation professional and can be a most valuable resource for those working with older persons.

Once again, it is important to keep in mind that the disability advocate must be mindful that gerontologists and rehabilitation personnel have differing areas of expertise. When making a referral, therefore, it is important to take the time to create a working partnership. As with any ongoing partnership, communication and follow-up is critical to insure useful and goal-directed outcomes for the client who is the central focus of the process.

It should be noted that this directory of area agencies on aging can be the starting point for investigating services either within the agency itself or in the community which provides programming geared for the older person. In addition, there are also special employment events (that often take place in various locations) designed for the employability of the older job seeker. This would include events such as job fairs, skill seminars and state or university-based job development conferences or meetings. Some subsidized training programs available through local area agencies on aging include, Green Thumb, Foster Grandparent, and Job Training Partnership Act (JTPA) funded programs.

The U.S. Department of Labor has several programs devoted to the aging worker that are worthy of investigation and use. Through the coordination of the Department of Labor, business leaders representing large through small size companies and labor, convene to discuss trends in technology, changes in the workplace, training of the workforce and policy implementation on various levels. Facilitation and consultant services are provided to the community service givers and specially tailored services are offered to individual job seekers. In particular staffing of these programs include older worker specialists who are trained and experienced in assisting the mature displaced or dislocated worker. Support groups for the older worker are available, as is direct job placement activities.

The American Association of Retired Persons (AARP), a national organization, is another valuable resource for the com-

munity. AARP through its *Worker Equity Department* offers job skills training in locations throughout the nation to a wide range of seasoned, mature persons as they have decided to "unretire" from retirement.

Some states offer a consortium approach to older worker issues. In New York, for example, an organization of concerned professionals gather quarterly on a regional or statewide basis. This network is called the Older Worker Employment Professionals of New York. At their scheduled events, issues and techniques of recruitment, training, placement and job retention are discussed and developed. These meetings provide a wealth of information and an exchange on the best ideas in working with older populations. From the New York experience, it is obvious that programs of this type have much to offer and should be duplicated in other states.

Conclusions

To summarize, the 1990s is an exciting time for planning and direct actions as it applies to the employment prospects for older job-seekers with or without disabilities. As we address the slowing of the growth of the nation's workforce, and the continual need to replenish the supply of workers with ever-increasing demands of the marketplace, it is important that we cultivate those older workers who can do the job. The older person who wants to work, whether it be full or part-time, should have the option to return to work in a realistic capacity. The decade ahead will require new commitments to cultivate and serve the needs of older persons with disabilities who choose to work and can be productive. Along these lines, those in the rehabilitative fields and business and industry need to develop new standards and approaches to workable partnerships to enhance the lives of older Americans.

References

American Association of Retired Persons. Work and Retirement: Employees Over 40 and Their Views, Washington, D.C. (1986).

DeSantis, Sandy A. Projects with Industry: The Concept and the Program. L.G. Perlman & C.E. Hansen (Eds.). Employment and Disability: Trends for the 1990's, Report on the 14th Mary E. Switzer Memorial Seminar, p. 68, Alexandria, Va.: National Rehabilitation Association (1990).

Janicki, Matt, Anderson, Donna Marie, Harward, Naomi. "Overview of Aging and the Work Force Characteristics, Corthell, David, & Fleming, Ken (Eds.) Aging in America Implication for Vocational Rehabilitation and Independent Living, Seventeenth Institute on Rehabilitation Issues p 4 Menomonie, Wisconsin: University of Wisconsin at Stout (1990).

Johnston, William B. "Workforce 2000, Executive Summary" Workforce 2000, Work and Workers for the 21st Century, p. xx, xxvi, Hudson Institute, Indianapolis, Indiana (1987).

Kohlberg, William H. "The Changing Work Place, Employment Policies: Looking into the Year 2000, p. 3. National Alliance of Business, Washington, D.C. (1986).

McLaughlin, Ann. "The Changing Work Force", Report of the Secretary, Labor Market Shortages p. 5, 12, 27, 29. U.S. Department of Labor, Washington, D.C. (1989).

McLaughlin, Ann. "Tomorrow's Workforce," Report of the Secretary of Labor, Older Worker Task Force: Key Policy Issues for the Future, p. 1. U.S. Department of Labor, Washington, D.C. (1989).

Rones, Philip L., Herz, Diane E. "Unemployment and Other Labor Problems," Report of the Secretary of Labor, Labor Market Problems of Older Workers, p. 6, U.S. Department of Labor, Washington, D.C. (1989).

Excerpts of Reviews and Comments

The author provides an excellent overview of employment of the older blind worker with a disability. Given the large percentage (60%) of the U. S. population with disabilities who are 45 years of age or older, there will be a definite need for more planning and networking in the 1990s. While the author did not specifically mention the Rehabilitation Act or the Older Americans Act, there certainly will be implications for the state/federal rehabilitation service delivery system in the future in terms of meeting the needs of this older disabled population. Additionally, there will be implications for the Social Security Administration as it relates to dealing effectively with various employment disincentives such as the SSI and SSDI program. The author pointed out a variety of approaches in accommodating older workers including job sharing practices and flexible work schedules. Additionally, other resources are available including the Job Training Partnership Act and consumer organizations such as the American Association of Retired Persons (AARP). Given the number of older workers with disabilities who will need employment opportunities in the 21st century, the state/federal rehabilitation service delivery system will certainly need to develop long range planning strategies for serving this population.

—J. Elton Moore

The evolution of rehabilitation programs and the adaptation of programs to rehabilitation philosophy would be an interesting and fascinating study in itself. Sisco's paper describes the adaptation of the Projects with Industry (PWI) model to meet the needs of the older worker. As Sisco has pointed out, the PWI program involves a link with private sector, a training site, and a clientele of persons with disabilities. Given the success of other programs utilizing the PWI model for a variety of rehabilitation clients, it would appear that PWI would be a "natural" for older workers.

A resource that has great potential within the model is the use of the business or industry advisory council. As Sisco points out, there is the need to educate employers as part of the process, employer cooperation as the driver of the process is often the difference between success and failure. The inclusion of both private and public employers along with a programmatic or support and training resources, can bring about a successful merging of the talents and abilities of an older person to the needs of business and industry. One of the more interesting notions presented is the use of the older person in designing training. This application of knowledge has not been applied to many populations including those of minority cultural and ethnic backgrounds. The perspective for training may be much more efficient if designed by the population to be served rather than the "cart before the horse" approach.

The paper certainly suggests that there is need to better evaluate the PWI process related to unique populations such as the older worker. The evaluation process for most projects has not been well thought out and often seems to be "after thoughts" rather than well conceived and designed. The implications are fairly clear that things are no longer as they were for both rehabilitation and industry and that there will be a need for flexibility on the part of programs, industry, and the older worker to develop jointly various alternatives that will serve all.

—Paul Leung

Sisco provides a good overview of what it means to be employed or unemployed and aged.

She is quick to assert that many older people need to work to maintain their financial independence. Also, on a broader scale, the market place appears to need older workers as numbers of younger people available for work decline.

It is often thought that early retirements and other departures from the work force are money saving by nature. Surely, the thinking goes, we lost a little experience but we also lose the higher salary and replace it with a younger person with new blood and fresh ideas to whom we will be paying less money.

Sisco points out a message that needs to be brought home very ardently, that early departure from the work force is costly to the displaced worker, to the employer and to the nation.

Several excellent and well tried ideas are summarized in the paper: job sharing, projects with industry and taking good and mutual advantage of the older person's flexibility as it relates to time, responsibility, perks and salary needs.

It is incumbent upon all of us according to Sisco to plan for the future with what is and will continue to be a burgeoning population.

—Richard P. Oestreich

Employers, and particularly small employers, need to be made more aware of the demographics of the aging workforce and the long term employment issues this creates. As the author points out, education is indeed key. Until employers come face to face with the shortage of qualified persons, they often are not motivated to go the extra step and investigate less traditional approaches, such as flexible work arrangements, community-based partnerships and outreach to rehabilitation agencies and other non-traditional sources of talent.

In the past, it has been primarily up to the employer to seek out government and non-profit social services agencies that might provide services of interest. As a result, one can speculate that, over the years, many services that have been available have not been fully utilized by employers. Communication between employers and public and non-profit sector agencies has been limited.

This trend must be stopped, so that rehabilitation and gerontological professionals not only work together, as the author suggests, but go a step further and include the employer in the information and service network. Public and non-profit sector agencies should aggressively reach out to employers to include them in efforts to maximize the talents and em-

ployment opportunities for older disabled workers, recognizing that employers need to be educated about the services and talent available, and, in turn, the agencies need to come to understand the specific skills requirements of the employer.

—Linda I. Workman

The PWI program has been in operation for 11 years. Sisco presents a model in *Aging in America* for the reader that would apply to issues in the disabilities area, although it says little about the population they serve regarding the specifics relevant to people with disabilities.

More needs to be said about how to improve and educate employers about the potential of older workers and disabled older workers in particular. The bottom line is that federal legislation (Rehabilitation Act) *must* create opportunities for the older disabled workers in order to have access to vocational rehabilitation and vocational rehabilitation counselors. Rehabilitation must be educated to explore work options with older clients *beyond* homemaker status.

There are 2.7 million over 65 years of age who are visually impaired and wishing to join the work force. Rehabilitation is not willing or able to raise this issue and does not work with elderly, visually impaired people because of the difficulties of job placement.

The reality of increased life expectancy creates many more years of productive activity. Older persons do not need 20-35 years of retirement. It is critical for older disabled persons (visually impaired) to receive rehabilitation while *maintaining* a job— learning adaptive techniques, equipment, job modification and environmental modification— *on the job.*

The cost of medical care is one of the major fears of the elderly person who works, in many cases for that alone. Partnership of business, aging workers and rehabilitation, could serve as a model for a federally funded project for replication of services to the elderly disabled client who wishes to work.

We can train the older worker and the older disabled worker all we want but if we do not educate employers (big business etc.) about their potential, it will never happen. This is where most of the education needs to take place— not with the elderly but with the employers who may hire them. What is needed is inservice training models for employers about the potential of older workers and disabled older workers in particular.

The field needs more information on the need for environmental modification, as well, specifically, in work environments related to specific disabilities.

Finally, the important points Sisco stressed include:

- listing resources
- discussing the need for gerontologists and rehabilitation personnel to communicate with one another
- recent statistics on employment issues and trends
- highlighting Projects with Industry and Aging in America as model projects.

—Susan Jay Spungin

Aging, Disability and the Nation's Productivity provides a framework for the discussion of older workers with disabilities. Ms. Sisco first outlines the importance of employment— as a measure of self-esteem, creator of social opportunities, and quite obviously as a provider of financial support. She follows with a discussion of the demographic and economic factors that will influence the treatment of older workers with disabilities.

Particularly useful is her acknowledgement that there are two groups to consider: older workers and employers. For both groups Ms. Sisco offers some suggestions. Older workers may respond better if the employer offered flex-time, job sharing, flexible benefits, education/training for new jobs; and employers might be more willing to hire older workers if older workers attempted to find out what they might do to make themselves the kind of workers employers want to hire. (It is worth noting that the employer perspective is often missing in discussions of potential workers.)

Ms. Sisco's views are important because she is on the lines daily. Her own program, that deals with older workers with disabilities is most impressive. The description of Aging in America/ Project with Industry provides an outline of techniques for potential workers and services for potential employers. A practical use for the description of the program would be an expanded, formalized version to use as a handbook for other potential Project with Industry participants.

It would be hard to disagree that the 1990s is the time to plan for the older disabled workforce. This paper gives us some valuable facts and ideas from which to begin our work.

—Laurel Beedon

Chapter Two

Serving the Older Worker with a Disability: The Role of *Re*habilitation

Jerold D. Bozarth

Literature and research concerning the role of rehabilitation with older workers who have disabilities are predominately cast in an *external* frame of reference. The terminology, "older worker with a disability" is a norm group from which descriptions are offered and which may lead to services and treatment for these individuals who belong to the particular category. Demographic analysis is one example of a readily observed external referent. For example, Blake (1981) considered demographic information as related to older people in order "...to provide indicators of their health and disability status, and to relate this to rehabilitation" (p. 19). Blake pointed out that the information gleaned in the survey was not highly precise even though important for identifying certain features. Blake's demographic analysis reached an important conclusion for political and policy making groups; namely, that, "In terms of age groups, participation in the rehabilitation service is apparently inversely related to the need for such services" (p. 19). This observation which was reached from careful analysis is one that may be useful for political decision making and for planning directions for rehabilitation services. It is, however, an inference about categories of individuals and is an external referent to any given individual. As such, this information may be useful as important political or economic facts to assist older people with disabilities but have little clinical meaning for the rehabilitation of any given individual. Individual energy and responsibility may often be lost in the anonymity of the collective.

The predominance of the external view is not limited to demographic studies. This view pervades all aspects of rehabilitation dealing with such items as health information, rehabilitation process, counseling strategies and theories of counseling and aging. One of the difficulties of focusing on an external referent is communicated by Rowe and Kahn (1987) who point out that: "Research in aging has emphasized average age-related losses and neglected the substantial heterogeneity of older persons" (p. 143). The internal view is generally taken for granted by being depicted with casual references and with little emphasis to individuality, self-determination or locus of control even though some authors (e.g., Bozarth, 1981; Jernigan, 1981) have emphasized the importance of individualism for elderly people. The action papers for the fifteenth Switzer Memorial Seminar reflect the focus on the external referent. The papers identify important considerations of the work roles, cost-benefits, public policy issues, attitudes and legal issues of older workers with disabilities. Even though such information and considerations may be critical for general clinical determinations and for fostering increased services for this group, the emphases are consistently external to the frame of reference of the individual.

The emphasis in this paper is upon the importance of the internal referent as the foremost foundation for *re*habilitation of the older worker with a disability. Indeed, the term, habilitate is defined "..to qualify oneself" (*Webster's Seventh New Collegiate Dictionary*, 1970). Rehabilitation is, then, a renewal of the qualification of oneself. The qualification of oneself may be through both the internal and external focus. Rehabilitation through an external framework lens is a renewal of the qualification of oneself from without; e.g., "to fit by training skill, or ability for a special purpose" and from the internal view, rehabilitation assists the individual "to acquire competent power" (*Webster's Seventh New Collegiate Dictionary*, 1970). It is the contention in this paper that the most potent resource of the "older worker with a disability" is that of the individual's inner potential and that the individual's clarification of his/her inner frame of reference is related to a natural constructive growth process. The internal clarification essentially empowers an individual enabling him/her to "qualify" the "self." General principles of an internal referent model for rehabilitation of older individuals with disabilities is offered. The emphasis on the individual as his/her own best source of energy and creativity is increasingly more prevalent in society at the macro level. There is a world wide societal evolvement for governments to change from central power to individual empowerment and from focusing on classes of people to focusing on the individual. Naisbitt and Aburdene (1990) aptly note:

Across the world, there is now a clear shift of emphasis to the individual from class or group (poor blacks, unwed mothers). In the past it has been: We are going to do this or that, for ***them****.*

JEROLD D. BOZARTH is a Professor at the University of Georgia, Athens, Georgia.

Now the focus is shifting to the individual. Surely what works best is a tailored program to match individual strengths and needs, to have government in concert with the private sector respond to each individual, not to classes and groups and categories. (p. 183)

They contend from their analysis of global data that: "The triumph of the individual signals the demise of the collective" (p. 323). And that in the evolution for rewarding people for individual efforts that: "It is the triumph of individual responsibility against the anonymity of the collective" (p. 323).

Personal empowerment is also reflected in Gorbachev's (1987) concept of Perestroika when he states:

Today our main job is to lift the individual spiritually, respecting his inner world and giving him moral strength. We are seeking to make the whole intellectual potential of society and all the potentialities of culture work to mold a socially active person, spiritually rich, just and conscientious. An individual must know and feel that his contribution is needed, that his dignity is not being infringed upon, that he is being treated with trust and respect. When an individual sees all of this, he is capable of accomplishing much. (p. 30)

The triumph of the individual is the great unifying theme of society as we enter the 21st century.

The trend towards increasing emphasis on the importance of the internal view for older persons with disabilities is reflected in *The Age Base Directory of Health Promotion Programs for Older Adults* (Kroll, 1989). The U.S. Surgeon General noted three "encouraging elements" (Koop, 1989) in the document. These elements were: 1) The tendency towards cooperation and coalition-building (p. i); 2) Diversity and individuality (p.i); and 3) Participation and self-help (p.ii). The programs listed in the age based directory resource book not only originated from grassroots movements but many of them developed from acknowledging the internal perspectives of older adults. Rubenfeld (1986), commenting on the proceedings on the first national conference on disability, rehabilitation, and the aged, reflects on the importance of the individual by saying: "Although the problem is immense, the solutions are relatively simple in conceptualization. Older disabled persons must control their own future" (p.339). Naisbitt and Aburdene (1990) identify the individual as the one "...who changes him or herself first before attempting to change society. Individuals today can leverage change far more effectively than most institutions" (p. 322). If older disabled persons are to control their own future, each individual can leverage change upon the external world much more effectively if they change him or herself first.

Nevertheless, the emphasis on the internal view is neglected in the majority of the literature on the older disabled person. Perhaps this view is considered implicit in the current clinical rehabilitation models. It is, however, a view that has been assumed rather than emphasized as critically important. It is a view that is seldom explicitly stated.

External and Internal Views

The External View

The "*external*" view refers to that view which comes from outside of the person receiving services. It includes such important information as demographic characteristics, disease proclivities, general treatment modalities and services available to older people who have disabilities. Additionally, it also includes speculations, generalizations, diagnoses, data about the person, theories extant of the individual's perception, and all views that are developed outside of the person's perceptual framework.

The Internal View

The "*internal* " view refers to that view which comes from the individual's perceptual framework. It includes dedicating treatment to correspond to the phenomenological world of the person and to allowing the individual to go in his/her direction, pace, and way. It is, first and foremost, trusting the internal process of the individual. The internal view is inclusive of the external view as long as the individual is permitted to orchestrate his/her own life from his/her own frame of reference.

Perspectives from Theories of Aging and Counseling

Theories of Aging

Most theories of aging are based upon external referents. The most prominent conceptions of aging as a social process are the theories of disengagement, activity and continuity (Atchly, 1977). Succinct summaries of these theories illustrate the focus of the external framework. Disengagement Theory views the aging process as mutual withdrawal between society and the older person (Cumming & Henry, 1961). Activity Theory views older persons as essentially the same as middle aged persons except for some biological and health changes (Havighurst, Neugarten, & Tobin, 1968). Continuity Theory comes closer to considering the internal referent by recognizing the complex nature of adjustment and personality (Atchley, 1977). Even so, these theories account for individual behavior from an external framework.

Theories of Counseling

Even though most counseling perspectives adhere to the importance of the individual's internal perspective; these counseling theories also approach the client from an external referent. That is, these theories assume a generalization that the individual must at some level fit. The psychodynamic, behavioristic and most of the humanistic approaches to counseling have basic assumptions that are external to the client's frame of reference. The emphasis is theoretically upon the question of: How does this person fit into the external assumptions of the theory? There are models that are associated with counseling for personal loss (Heikkinen, 1979), for specific disabilities (Cull & Hardy, 1975), and for older individuals (Wolff & Myer, 1979). Some authors believe that rehabilitation of older clients is a process that requires specific knowledge and skills (Finnerty-Fried, 1985; Finnerty-Fried, Myers & Barry, 1986; & Myers, 1985). Varied techniques for working with older adults are reported in the literature (Myers, 1990). These techniques include "Early Recollections" (Sweeney, 1990), "The Life Review" (Waters, 1990), "Multimodal Therapy" (Weikle, 1990), specified techniques for crisis theory and management of individuals and families (Duffy & Isco, 1990), and particular group counseling procedures for particular disabilities (Hittner & Bornstein, 1990). Specific

strategies are often provided for assisting older adults to become empowered (Waters & Goodman, 1990). The question seldom focused on is the one related to the internal view which is most closely related to the "qualification of oneself" as acquiring competent power of self. The question from the internal view is the question: What is the view of the world of the person from his/her own frame of reference? The most notable general models that theoretically focus upon the internal referent are Logotherapy (Frankl, 1962) and Person-Centered Therapy (Raskin & Rogers, 1990). The latter theory offers more clinical examples and is more functionally and exclusively focused upon the internal referent of the individual. I (Bozarth,1985) have, for example, argued that Person-Centered Therapy operates on a different paradigm from other therapies due to the extent of commitment to the self-authority of the client and to the focus on the client's capacity to go at his/her own pace, own way, and own direction. A major functional difference of this theoretical stance from other stances is that the therapist does not hold preconceptions of what the client should do, be or become (Bozarth, 1989). Although the thesis of this paper is not about implementing Person-Centered Therapy with older individuals with disabilities, it does adhere to the central construct of person-centered theory. Namely, the counselor (and other rehabilitation professionals) trust that the individual will move in a constructive direction. The most basic person-centered value is that the authority about the person rests in the person rather than in an outside expert. This value is the critical value inherent in emphasizing the internal rather than external referent. The underlying clinical philosophy of the internal referent is presented by Bozarth & Brodley (1984) in the following statement:

It is when, no matter how subtly, the helping person begins to presume the authority of knowing better than the person being helped— what hurts, what directions the person should go, or what problems are crucial to be solved— that the fundamental person-centered values are violated. It is, from our perspective, when the helping person assumes authority over the experience and autonomy of the helped person that the foundation of the approach is distorted and lost. (p. 9)

The value of the internal referent has simply not been given due attention in discourses on rehabilitating the older person with a disability. The opportunity for the individual to internally qualify oneself from his/her own perspective is usually not the first consideration in the rehabilitation counseling model.

Some Viewpoints of "Older" Individuals

Qualitative research generates theory from the phenomenological world of the culture of persons being studied. Since the rehabilitation literature concerning older adults with disabilities are predominantly from the external frame of reference of these individuals, a view from a more internal perspective seems appropriate. What do "older" individuals have to say about their rehabilitation? One of the most revealing findings occurred nearly a decade ago in an unpublished project at the University of Georgia. The project, which I identify as the Oconee County Project (Bozarth, 1981), was completed by a sociologist at the University of Georgia (Fletcher, 1980). The intent of this project was to provide an elderly group of individuals the opportunity to express themselves and to qualitatively describe their expressions. The group consisted of approximately fifty individuals who were between the ages of sixty-five and ninety-five who resided in a geriatric rehabilitation center. The results are described below:

Some of the major themes which were identified from analysis of tape recorded interviews included repeated reference to the importance of independence; differences between "generations" in life styles; and the societal problems of forced unemployment, fixed income, and high medical costs. Several of their specific recommendations to counselors included suggestions 1) to be patient and willing to work hard and use common sense beyond academic knowledge, 2) to be able to listen 3) to be cognizant of age differences, experience differences, and life style differences and the strengths associated with these differences, and 4) to help make more accessible to them those resources that provide for "concrete" help. They did not want to be "cared for" or "taken care of" or have helpers do things for them. (Bozarth, 1981, p. 31)

Such conclusions emerge when individuals are given the opportunity to express themselves from their own internal perspective. Similar conclusions have emerged in person-centered community groups (Bozarth, 1981) which other facilitators and I have had with individuals who have ranged in age from sixty-five to one hundred and three years old. Jacobs (1974) who had earlier examined a retirement community of 5,600 members also reported that older individuals espoused independence and self sufficiency.

Carl R. Rogers (1980) captures the theme of the internal referent in his paper titled: "Growing Old or Older and Growing." He stated that he really did not feel any different at the age of seventy-five than he did at the age of forty-five except for several physical limitations. Beyond this agreement with the Continuity Theory, he identified his own unique goals and activities that included international globe trotting to work as a facilitator in intense large groups, to give lectures and so on. In an addendum to his paper when he reached the age of eighty-five, Rogers (1987) discusses his major participation in numerous workshops dedicated to international peace efforts in Russia, Northern Ireland, South Africa and Central America. Interestingly, he comments: "From a personal point of view, I look with surprised satisfaction on the fact that I have been able to participate in dealing with such crucial conflicts. I would have never dreamed of such events at the age of sixty five" (p.151).

At a slightly younger age, I have been impressed with the effects of some activities undertaken by older citizens. A most notable example is presented by George Leonard (1985) who describes some of his experiences in acquiring a black belt in Aikido at age fifty-two. Aikido is a form of martial art which demands falling, rolling, and intense physical and mental discipline. Leonard describes his experience in relation to age:

The results shatter some cultural stereotypes. Older people are supposed to be stiffer, less resilient than younger people, but as my years of Aikido have passed, I've become steadily more supple and flexible. Older people are supposed to heal less readily, but my injuries have healed just as fast as, and sometimes faster than, anyone else's in the dojo. Older people are supposed to be resistant to learning, set in their ways, but I feel I'm a much faster learner now than in my youth. The fact of the

matter is, I can do everything now that I could do in my twenties and a lot that I wouldn't have dreamed of doing. (p. 86)

My own experience is somewhat similar to George Leonard's experience except that I started Aikido at age fifty-seven and with a chronic pulmonary disability. My intention is to acquire a black belt at age sixty-two.

The Internal Referent Model

As an extension of qualitatively viewing the experiential world of older persons with disabilities and my own experiences, I propose some general principles for an internal referent model for rehabilitation professionals to work with older individuals with disabilities.

Theoretical Base

The internal referent model in rehabilitation counseling was prevalent in the initial development of the Facilitative Management model (Bozarth & Rubin, 1972). The term, Facilitative Management, refers to the unique model of rehabilitation counseling that can integrate the action oriented resources of the rehabilitation counselor with the internal frame of reference of the client as the client develops his/her self concept in the world of work. It is, thus, that the internal referent of the client for his/her own life can be the focus and resources are available to assist the client to make his/her self-concept in the world of work a reality. The model is applicable to the older worker with a disability in that the focus on the individual's frame of reference assists the person to clarify his/her views of the world and also assists the person with making this view a reality. A more formal definition of the internal referent model for working with the older person with a disability is a rendition of Super's definition of vocational guidance. The recast definition is the following:

The intention of the counselor is to help the older individual with a disability to develop and accept an integrated self-concept; to help the individual to test that self-concept; and to help make that self-concept a reality.

The basic premise for the model is the following:

When a facilitative psychological climate emphasizing the individual's internal frame of reference is experienced by the individual who assumes the locus of control for his/her life, constructive growth is promoted.

The "*internal*" view, as previously stated, refers to the internal frame of reference of the individual. The internal view focuses on the importance of the individual's self determination and self responsibility rather than upon speculations about the person outside of his/her frame of reference.

The Functional Role

The functional role of the counselor is to understand the world of the client from the client's frame of reference. Unlike the counselor who has an external perspective, it is the intent of the counselor to eliminate all preconceptions about the client. All conceptions such as what the client is like, what the client is likely to do, be or become are minimized by the counselor. The counselor's role is, thus, to absorb him/herself in listening to and experiencing the client. The abiding intent is to understand the client's view of the world from his/her frame of reference and to discover what the client means with his/her communication. The primary implementation by the counselor is, thus, to check with the client about whether or not the counselor correctly understands the client's meaning. When the client reaches a conclusion about him/her self in relation to the world (or develops a more fully integrated self concept), the opportunity to test this self concept may be offered by the counselor in a form consistent with the individual's conceptualizations. For example, a client who essentially concludes, "I am a person willing and able to work two days a week" might be given the opportunity to try to work on a volunteer basis for a short time as a test of the consistency of that self concept. If successful and the self concept is integrated, the counselor may assist the person to find an appropriate job.

In summary, the activities of the counselor attending to the internal referent are:

- to absorb oneself in listening to the client and experiencing the client;
- to check out the understandings of the client's perception of the world as the counselor understands that world at any given time;
- to act consistently in concert with the client to test and activate that self concept;
- to not interfere with the client's development of the internal referent.

Examples

An Example in a Group

A scenario from a group of older individuals with disabilities is presented as an example of attending to the internal referents of individuals and of not interfering with their natural development.

Three facilitators offered a person-centered "community group" for participants in a day center rehabilitation program (Bozarth, 1980). The program was designed to provide these older adults with disabilities with activities and medical attention during the day. The goals of the facilitators in the community group were simply to provide the participants with the opportunity to express themselves and to allow them to determine their own directions. The group consisted of sixteen women and seven men ranging from age sixty-nine to one hundred and three. Their disabilities included arthritis, cancer, emphysema, stroke, and several psychiatric diagnoses. The stance of the facilitators was that of encouraging and accepting the expressions of the participants without interfering or directing either the individuals or the group. The facilitators did from time to time express their own feelings and thoughts or share personal activities. The philosophy was consistent with that of person-centered community groups (Bozarth, 1982). The group met for six months one time per week for two to three hours. Most of the participants remained in the group although two died and one quit. Individuals entered the group at various times throughout the six months. A summary statement from a facilitator's journal (Bozarth, 1980) provides an overview of the initial process:

This fourth meeting seems significant...the members no longer look for direction from the facilitators. They seem pleased and free to talk about anything. During the last two meetings over half of the members expressed recollections about their lives. Even Harold (98 years old) who has said little talked

about boyhood experiences. I shared my naivete with them about my perception that so many of them seemed to have lung problems since they were continuously spitting up blood. I had noticed that about three-fourths of them were frequently spitting into cans. After the three meetings, I finally realized that they were chewing tobacco (So much for my expert diagnosis).The women, especially several of the black women, got a hoot ou. of that...I thought that the group became even more internally directed after this episode....(p. 7)

Another note after the eighth session depicts a uniquely internal development:

Mary (a 73-year-old black woman)has taken the leadership of the group. She discusses religion quite a bit and suggested today that she pray and that the group sing a religious song at the termination of the group session. The members with the exception of Harold and maybe Julia (a 76-year-old white woman) seemed to be quite receptive to the idea. It turned out to be rather inspiring to most of them. They were more energetic and active and interactive the remainder of the day in their other activities. (p.11)

These scenarios from the journal notes may provide some sense of the dedication to the internal frames of reference of the participants of this particular group. Rather than relating the process of the group to an external theory, the focus was upon allowing the views of the worlds of the participants to dominate. A note in the journal summarizes our thoughts about the group experience:

The last group meeting was today. We (the facilitators) sometimes wonder what happened. It is clear that there have been significant behavior and attitude changes with most of the people who participated for any reasonable time. Four of them who were obviously depressed at the beginning of the group are now enthused and actively involved in center activities; two of them decided that they do not like coming to the center for their activities. They now come only for their medical checkup and medicine at which time they visit with others and express happiness with their decisions. Each member, except perhaps Harold, reflects a more involved and active attitude and I sometimes imagine that I see a glint of knowing and stubbornness in his eyes. Nevertheless, center staff attendants and nurses and relatives of the participants have remarked about the noticeable differences that they perceive in most of the people involved in this community group. One of the most surprising things about this experience is that our decisions to trust even the most ostensibly bizarre directions of each individual turned out to be the more helpful occurrences to them. Mary's reversion to revivalism religion is one of the most clear examples. The group began to often sound like a church revival meeting; especially, during the prayer time and the singing of gospel songs. Yet, even those individuals who were skeptical about the specific undertakings became caught up with their own unique expressions within this religious context. Any direction that we as experts might have provided could not have held a candle to the spontaneous development that emerged from the broad experiences and varied perceptions of this array of individuals. (p.89)

The emphasis upon the internal frame of reference of the participants is obvious from the above journal notes. The relationship to the internal referent model is, perhaps, less obvious. In this group situation, each individual was almost entirely responded to in ways that respected his/her internal frame of reference. The individual's perception and experience was regarded as the most important aspect of his or her rehabilitation. The individuals in a real sense were allowed to become their own best experts about their lives. Many of them clarified their self concepts and adjusted their internal freedom compared to the external restrictions of particular disability and environment. In some cases, staff members were able to help the clients' decisions to become realities, for example, by altering programs to accommodate those who did not want to come to all activities in the center. It seems reasonable to conclude that most of these older individuals with disabilities in this group were ***rehabilitated. They had qualified themselves internally*** *by developing more integrated concepts of themselves and found more personal power. They were externally qualified through assistance from rehabilitation personnel to take action on their decisions. There was an integration of the internal and external views of rehabilitation.*

The implementation of the internal referent model with the group domonstrates the natural process taken by this particular group which followed some procedures that might typically be recommended from an external framework (e.g., early recommendations) and some procedures that were unique to the group (e.g., religious activities that included praying and singing gospel songs). The next section depicts the implementation of the internal referent model with an individual.

An Example with an Individual

The following example is taken from my consultation (Bozarth, 1986) with a bereaved seventy-four year-old disabled man, "Bill", who had recently lost his wife. Bill had diabetes since age fifty but controlled his diabetes with diet and daily injections of insulin. He did not consider his disability to be a handicap and viewed himself as an independent individual. Bill had retired from a professional job as a technical writer fourteen years before the date of our consultation meeting. He had been physically active with an avocation of tutoring a few tennis students until his wife with whom he had been inseparable became seriously ill with cancer. He spent nearly six months exclusively caring for her. He became deeply depressed shortly after her death and his normally good physical health began to deteriorate. Bill's physician referred him to a "grief group" and suggested that he get involved in activities as much as possible. Although these were "external" referent suggestions, they were tailored to counter Bill's feelings of depression, loss and general lack of interest in living.

Bill's first meeting with me was along the following line (B=Bill; C=Counselor):

B. I just can't get interested in tennis anymore. I'm going to the class to help with it, but I don't really want to do it. Tennis used to be a way for me to let out my feelings but it just isn't working.

C. You were thinking that might be the ***one*** *thing that would help you let out your feelings but even that isn't working?*

B. Yeah, but nothing is working. I even followed Doc's advice and went to this group. I'm trying but I just don't know.

C. Um huh.

B. Well, you know, that might be helpful for some but we are supposed to do things like write my wife a letter about how I feel. I guess I'm supposed to be angry at her. Maybe this kind of thing is good for some but it just isn't for me. It just makes it harder for me.

C. So It's o.k. for others but not really the thing for you because it makes it even harder.

B. Yeah, well, you know, I've just always solved my own problems all of my life...took care of my diabetes with diet and shots when they said I should stop a lot of my activities. Slow down they told me. Well, you know that is just not me.

C. It is like it is important to you to do things your way.

B. You're damned right.

(Five minute silence)

B. I just don't think I'm going to do that letter writing. It's just too hard for me. I don't really want to stay in that group but I do like the people in it.

In this short segment, the counselor did not assert external suggestions and, in fact, did not assume any external interpretation of Bill's concerns. Bill's remarks were simply reaffirmed in an effort to understand the way Bill viewed things. The entire session continued in that vein. What became clear was that Bill did not view the "external" recommendations as helpful to his continued depression and feelings of loss. This was reconfirmed in the next session:

B. I tried to write that letter and I can do it but it just is not helpful. It makes me feel worse. I know that this is supposed to help me work through it but it ain't. (C. yeah) I also don't want to talk about the way I feel to that group. They are o.k. but I just don't care to be that way with a bunch of people.

C. You mean being emotional is not something you care to do with a group or this group of people?

B. It is just not the way I am... to let everyone know how I feel.

As Bill continued this session and one other, two themes were clear. First, he had his own ways of doing things. He appreciated efforts to help him but was not inclined to follow suggestions that did not fit his own concept that, "I do things my way." Second, he was clear that: "I am not a group person. I am a loner." The third session revealed that Bill also viewed himself as "A bit of a hustler..." and that he had decided to take some action on his own. He subsequently quit going to the grief group. He continued to periodically help with the tennis class. However, he started to solicit some of the tennis students for individual tutoring and had ended up "... having more tennis students than I can handle." He developed several individual relationships with two women from the group and met frequently with them. Indicative of his way of doing things, he took a tap dancing class (trading tennis tutoring lessons for the class tuition) that provided him with the ideal mix of group and individual contact within a framework of physical activity that seemed more suited to his preferred way of doing things.

Bill's depression is now gone. He still feels the loss of his wife but increases his physical activity when it becomes "too hard" for him. He has reinstated his program for improving his physical well being and has formed relationships with several "younger" women. It was not necessary that the counselor assist Bill by providing particular services other than the counseling sessions to achieve his goals. He did it himself.

Bill's particular views provide a classic demonstration for the importance of emphasizing and trusting the internal rationale rather than approaching him from an external stance. He was internally adamant in his position that he did things his own way. He did not like the idea of other people telling him what was best for him. He found his own way, in part, with the unique therapeutic rehabilitation treatment of "tap dancing lessons." The external referent even when tailor made for Bill was not the best way for him to proceed. As Bill concluded in the last consultation session: "I just lost who I was for awhile. When I had a chance to realize that it was up to me and I wanted it to be up to me...then I knew I would make it." Bill had *requalified* himself. He was internally and externally ***rehabilitated***!

Summary

This paper challenges rehabilitation professionals to assist older people with disabilities to develop their self concepts from their internal frames of reference rather than to thrust upon them the external referents so prominent in rehabilitation literature and research. A model that would foster emphasis upon the internal referent is introduced and several short examples are presented. Rehabilitation professionals can emphasize the internal referent and trust the older individual with a disability to "qualify him/herself" from an internal frame of reference. Resources can then be offered in concert with the individual's own development of self. Thus, the older disabled person can find his/her respect and dignity by being his/her own best resource for ***rehabilitation***.

References

Atchly, R. C. (1977) *The social forces in later life*. Belmont, Ca.: Wadsworth (1977).

Blake, R. (1981) Disabled older persons: A demographic analysis. *Journal of Rehabilitation*, *47*(4), 19-27 (1981).

Bozarth, J. (1980). A community group with older disabled individuals. *Journal Notes*, unpublished document.

Bozarth, J. (1981) The rehabilitation process and older people. *Journal of Rehabilitation*, *47*(4), 28-32.

Bozarth, J. (1982). The person-centered community group. In G. Gazda (Ed.). *Innovations to group psychotherapy (4th ed.)*. Springfield, Ill.: Charles Thomas.

Bozarth, J. D. (1985). Quantum theory and the person-centered approach. *Journal of Counseling and Development. Special issue*, *64*(3),179-182.

Bozarth, J. D. (1989). The essence of client-centered & person-centered therapy. (pp. 88-99), In G. Lietaer, J. Rombauts, & R. VanBalen (Eds).*Client-Centered and Experiential Psychotherapy Towards the Nineties*. Leuven: Katholieke Universiteit te Leuven.

Bozarth, J. (1986). *Casenote file*. Unpublished document.

Bozarth, J. & Rubin, S. (1972). *Facilitative management*. Champaign, Ill.: Stipes Publishing Co.

Bozarth, J. D. & Brodley, B. T. (1984). Client-centered/person-centered psychotherapy: A statement of understanding. *Person-Centered Review*, 1(3), 262-265.

Brodley, B. T., & Bozarth, J. D. (1986, September). *The core values and theory of the person-centered approach*. Paper

presented at the meeting of the Association for the Development of the Person-Centered Approach. Chicago, Ill.

Cull, J. G. & Hardy, R. E. (1975). *Counseling strategies with special populations*. Springfield, Ill.: Charles Thomas.

Cumming, E., & Henry, W. H. (1961). *Growing old*. New York: Basic Books.

Duffy, M. & Isco, I. (1990). Techniques for individual and family counseling crisis theory and management. *Journal of Mental Health Counseling*, 12(3).

Finnerty-Fried, P. (1985). Adapting rehabilitation counseling for older persons, *Rehabilitation Counseling Bulletin*, *29*(4),135-142.

Finnerty-Fried, P., Myers, J. E., & Barry, J. R. (1986). Rehabilitation of older persons disabled by cancer, stroke, and heart disease. *Rehabilitation Counseling Bulletin*, *29*(4), 266-277.

Fletcher, D. (1980). *Older citizens in Oconee County, Georgia*. Unpublished report.

Frankl, V. E. (1962). *Man's search for meaning*. Boston: Beacon Press.

Gorbachev, M. S. (1987). *Peristroika: New thinking for our country and for the world*. (1st ed.) Cambridge, New York: Harper & Row.

Havighurst, R. J., Neugarten, B. L., & Tobin, S. S. (1968). Disengagement and patterns of aging. In B. L. Neugarten (Ed.), *Middle age and aging*. Chicago: University of Chicago Press.

Heikkinen, C. A. (1979). Counseling for personal loss. *Personnel and Guidance Journal*, *54*, 46-50.

Hittner, A. & Bornstein, H. (1990). Group counsleling with older adults: Coping with late onset hearing impairment. *Journal of Mental Health Counseling*, 12(3).

Jacobs, J. (1974). *Fun city: An ethnographic study of a retirement community* . New York: Jerry Jacobs.

Jernigan, J. (1981). Loss of physical function and disability: Health problems of older people. *Journal of Rehabilitation*, *47*(4), 34-37.

Koop, C. E. (1989). Preface. In J. Kroll (Ed.), *The age base directory of health promotion programs for older adults* (pp. i-ii), New York: The Brookdale Foundation Group.

Kroll, J. (Ed.), (1989). *The age base directory of health promotion programs for older adults*, New York: The Brookdale Foundation Group.

Leonard, G. (1985). On getting a black belt at age fifty-two. In R. S. Heckler (Ed.), *Aikido and the new warrior*, Berkeley, Ca.: North Atlantic Books.

Myers, J. E. (1985). Using links to help older disabled persons with transitions. *Rehabilitation Counseling Bulletin*, *29*(4), 143-149.

Myers, J. E. (1990). Techniques for counseling older persons. *Journal of Mental Health Counseling*, 12(3).

Naisbitt, J., & Aburdene, P. (1990). *Megatrends 2000*. New York: Avon Books.

Raskin, N. & Rogers, C. R. (1990). Person-centered therapy. (pp. 155-194), In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies(4th ed.)*, Itasca, Ill.: F. E. Peacock Publishers Inc.

Rowe, J. W., & Kahn, R. L. (1987). Human aging: Usual and successful. *Science*, 237, 143-150.

Rogers, C. R. (1980). *A way of being*. Boston: Houghton Mifflin.

Rogers, C. R. (1987). On reaching 85. *Person-Centered Review*, 2(2), 130-132.

Rubenfeld, P. (1986). Ageism and disabilityism: Double jeopardy. (pp. 323-328), In S. J. Brody & G. E. Ruff (Eds.), *Aging and rehabilitation: Advances in the state of the art*.

Super, D. E. (1981). Vocational adjustment: Implementing a self-concept. *Occupations*, *30*, 89-92.

Sweeney, T. J. (1990). Using memories in counseling older persons' early recollections. *Journal of Mental Health Counseling*, 12(3).

Waters, E. B. & Goodman, J. (1990). *Empowering older adults*. San Francisco: Jossey-Bass Inc. Publishers.

Waters, E. B. (1990). The life review: Strategies for working with individuals and groups. *Journal of Mental Health Counseling*, 12(3).

Webster's Seventh New Collegiate Dictionary. (1970). Springfield, Mass.: G. & C. Merriam Company, 373.

Weikel, W. J. (1990). A multimodal approach in dealing with older clients. *Journal of Mental Health Counseling*, 12(3).

Wolff, A. R. & Myer, G. W. (1979). Counseling older adults: Suggested approaches. In M. L. Ganikos (Ed.), *Counseling the aged: A training syllabus for educators*. Falls Church, Va.: American Personnel and Guidance Association.

Excerpts of Reviews and Comments

This paper has clear implications for the employment arena. Given the author's statement that "the most basic person-centered value is that the authority about the person rests in the person rather than in an outside expert" and given the author's development of that concept, it is implicit that employers must become better educated about disability and the older worker so that stereotypes and myths which have been externally generated can be dispelled. This will result in improved access to employment for older disabled workers, since they will be considered for employment on the basis of their individual qualifications, with reasonable accommodation as needed.

Educational efforts should be focused on smaller employers, where the presence of stereotypes and myths about the capabilities of older workers and disabled workers may not yet have been challenged.

Rehabilitation specialists can assist in increasing employment opportunities by linking closely with employers to present the qualifications of clients, as individuals, in relation to the job skills needed for a particular position.

—Linda I. Workman

Serving the Older Worker with a Disability.... focuses on the "internal referent or internal view" as a counseling basis for rehabilitating the older worker with a disability. This focus has implications for training and educating personnel, the consumer and the general public as well as for service delivery. In addition, the "internal referent" focus has implications for research which has routinely focused on external referents such as statistical analysis of demographic factors and chronic conditions.

The philosophical view held by the author, Jerold D. Bozarth, places value in the uniqueness of each individual, rather than the more "objective" approaches which tend to classify and categorize differences and come out with generalizations which are highly impersonal. Operationalization of the more objective approaches also seem to result in the creation of a hierarchy of professional and consumer, with the professional on top. Bozarth, thus, penetrates to the core of the dispute between the disability community and vocational rehabilitation on the value of experiential versus professional expertise. Bozarth's philosophical orientation is thus highly relevant to the current dialogue on reauthorization of the Rehabilitation Act.

However, the question of how to operationalize "inherent referent" in counseling and other settings or processes deserves some concrete examples. Further, the "inherent referent" construct should be clarified so that the goal of individual empowerment can be distinguished from atomization. The limitations of "inherent referent" should be made explicit especially at the point of interface with more objective constructs such as the role of coworkers, personnel and service providers and the formal framework of personnel and other procedures and structures. In service delivery, what are the implications of "inherent referent" for peer counseling techniques? In research, how will data be collected to test the efficacy of this construct?

—Katherine D. Seelman

The implication for a service provider here is very clear: bring to the rehabilitation counseling session no preconceptions based on age or any other factor. The counselor needs to listen carefully to the client and pay particular attention to his or her experience. The task of the service provider is to assist the older person to reach inside him or herself and share past experiences and feelings in order to make appropriate and meaningful plans for the future.

The attempt is to restore individuality to service to the older person with a disability. We have all read too much research on aging which speaks in averages of age-related losses and behavior, often to the neglect of a substantial heterogeneity among older persons.

It is also important to be careful not to see the aging process itself as the disability. The cause of the disability may or may not be caused by, exacerbated by or affected in any way by age.

Bozarth's group model seems to be a very effective approach with a population of people who grew up probably with no experience of sharing intimate thoughts and feelings with others. Even "uneducated" long term experiences may be very helpful compared to some of our "enlightened" younger ones.

A question I had as I read the paper related to the wisdom of age. While I think it is real, I also think it is possible to be very idealistic about this wisdom. Many of the older people with disabilities that I have met are simply lost, frustrated and in deep grief. They need direction, attention and just plain help.

Still I agree with Dr. Bozarth that the referent and focus for this assistance should be from within the client.

—Richard P. Oestreich

Dr. Bozarth's paper presents a very thought provoking challenge to rehabilitation counselors working with older individuals with disabilities. Historically, an "external view" has been established and practiced in the health, rehabilitation, and social service fields. The limitations of this approach are well documented.

A more "internal view" is proposed to maximize the rehabilitation success of older workers with disabilities. This approach would emphasize self-empowerment and self-advocacy by these rehabilitation clients. Efforts should be directed at raising the client's self-perceptions and esteem in order that he/she may face the challenge of finding employment in the open labor market. Research has demonstrated that with other minority groups who historically have experienced employment discrimination, success in the labor market is positively correlated with measured self-esteem. In other words, workers who have positive self-images are less likely to fall victims of discrimination. Put quite simply, they are more

likely to have the self-confidence needed to fight for their legal rights to employment.

Adopting an "internal view" for counseling in rehabilitation would require a major shift in traditional rehabilitation philosophy. The traditional medical model of illness and disability suggests that individuals are not responsible for the cause or cure of their conditions. Consistent with the "external view," medical and rehabilitation professionals will treat the condition and help the person reach his/her highest level of vocational and independent living functioning. In contrast, the "internal view" emphasizes a more holistic model that acknowledges the person's contribution and responsibility to his/her condition and rehabilitation. Obviously, training programs preparing rehabilitation professionals need to emphasize the counseling philosophy/orientation proposed by Dr. Bozarth. Research examining the effectiveness of this model is also warranted.

—James Bordieri

Dr. Bozarth's paper emphasizes the importance of understanding the internal motivations of the individual when preparing a rehabilitation program.

I have a major concern that this may be seen as an argument for a voucher approach to rehabilitation. It is a concern for two reasons: 1. the current system has evolved over the past seventy years to be an effective and viable system which would be dismantled by a voucher system and 2. the current system provides for individual development and focus of rehabilitation programs. The voucher system may work for a very limited portion of the population served by RSA but not the vast majority of persons with disabilities. The service delivery system is too complex and instead of improving quality through competition, I believe that a system of poor quality high cost would be set up as the process for large scale purchase and accountability decreased. Also it would not work without a dramatic increase in funding. If there were such an increase, I think that it would be best made under the current system. For example, the current approximately $1.7 billion would be divided evenly to the million participants in last year's program (without including any administrative cost) to be $1,700 per disabled person. With this, the individual could purchase counseling, guidance, equipment, restoration services and the myriad of other services purchased currently through VR. For many this would not be sufficient while others would have funds when not necessary. There would be no consideration of last use of federal funds and major problems with eligibility to participate as part of the chosen recipients. The need could easily be 20 million leaving a grand sum of $85 per participant. How would this meet the need of individuals with severely disabilities espoused under the Rehabilitation Act? In essence it would turn a highly functioning rehabilitation program into an ineffective and unaccountable welfare program.

The concepts of the importance of consideration of the internal perspective in the employment and rehabilitation process is very appropriate. This viewpoint fits nicely with the equitable flexibility described in Rupert's paper and furthers the argument for this concept. Making individual approaches to the rehabilitation and employment of each person with a disability has long been known in VR as the secret to success. I am uncertain that the approach that individuals will rehabilitate themselves as indicated by his example will always prove true.

I enjoyed his observation that as people age they increase their diversity in contrast to the philosophy that all older people are the same. His paper was limited in focus but valuable in its message. *(The opinions expressed are those of the author and not official RSA positions.)*

—John Nelson

Chapter Three

Employment of Older Workers with a Disability: Attitudes and Legal Issues

Malcolm H. Morrison

Introduction

Title 1: Employment

"No covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment."

—Public Law 101-336, The Americans with Disabilities Act

"They have been forced into a twilight zone of existence, because of outdated stereotypes, inadequate accommodations and a current system which is tolerant of an unjustifiable status quo."

—Senator Tom Harkin

"I believe that the Americans with Disabilities Act will help create a more inclusive America, an America that does not place needless and harmful barriers in the way of her citizens with disabilities."

—Senator Robert Dole

The passage in 1990 of the Americans with Disabilities Act (ADA), a landmark Civil Rights law protecting persons with disabilities, promises to effect major change toward eliminating discrimination against persons with disabilities in employment, public services, public accommodations, and telecommunications, throughout the United States. The enactment of the ADA reflects a long standing policy tradition that attitudinal barriers and their consequences— discrimination— can be remedied through legislation which establishes legal standards and protections. This policy tradition is responsible for the Civil Rights Act, the Age Discrimination in Employment Act, Sections 503 and 504 of the Rehabilitation Act and other similar laws.

There is a continuing debate about the effectiveness of civil rights laws in reducing discrimination and increasing opportunities for participation in economic and social life. Measuring effectiveness has been nearly impossible because of difficulties in evaluating cause and effect. But, there is no question that civil rights laws have resulted in less discriminatory behavior by business and industry, government, education, housing, health and other sectors and this behavior has reduced discriminatory attitudes and perceptions. Therefore, in the case of the ADA, the appropriate question to ask is not "how many new jobs will the ADA create?", but rather — "how can using the ADA change behavior, attitudes and policies to provide job opportunities for persons with disabilities?"

The interaction between attitudes of persons who hire workers and the legal provisions of both the Americans with Disabilities Act and the Age Discrimination in Employment Act will determine the extent to which policy changes will occur. To a significant degree, the extent of new employment for older persons with disabilities will depend on smaller and medium sized employers in the U.S. where most new job growth will take place.

It is a well known fact that early retirement and age discrimination in employment practices have resulted in reducing labor force participation of men 65 years old and over to 16.4 percent while that of "older" women remains under 10 percent. Since 1970, for men 55-64, labor force participation has declined from 83 to 68 percent (women's labor force participation declined one percent). Today, only 2.8 percent of the labor force consists of persons age 65 or older and just 9.5 percent of workers are 55-64 (U.S. Bureau of Labor Statistics, 1985, 1986; Fullerton, 1989).

Almost all studies of retirement behavior indicate that: (1) labor force withdrawal by older workers is related to availability of Social Security and private pensions; and (2) that health problems and job termination also result in early labor force withdrawal. While some older workers desire to work (usually part-time) and many who do not work are theoretically able to do so (up to 1.1 million according to some estimates), drawing them into the workforce is difficult. Almost all persons 60 and over not in the labor force say that they are not interested in working. Basically, older workers seem to become "very choosy" about what they do, particularly if the economic need to work is substantially reduced (Schulz, 1988).

MALCOLM H. MORRISON is Director of Research and Program Development, National Association of Rehabilitation Facilities, Washington, D.C.

So far as older workers in general are concerned, they have become a part of the diverse workforce which will characterize America's labor pool through and beyond the turn of the century. With fewer younger workers available, older workers, minorities, women, persons with disabilities, etc., will be available to employers. The extent of hiring older workers and those with disabilities will depend on employers being convinced that this is in their best interest; i.e. such workers are valuable employees who clearly contribute to productivity (Rix, 1991).

Disability is a major cause of reduced labor force participation by older workers. Unfortunately, there is a 30 percent probability that a young person entering work today will become disabled before age 65. In 80 percent of these cases, the disabling condition will occur after the person is 45 years old. For example, the average age for strokes and cardiac problems among employed persons is 56, and on average, persons leaving employment because of arthritis are age 54.

Today, over 70 percent of all workers receiving disability income payments leave the workforce between ages 45 and 64. About 500,000 older workers leave employment every year because of disabling impairments. Yet, nearly 60 percent of those experiencing impairments between ages 45 and 54 return to work as do 27 percent of those age 55-64. Most of these "returnees" do not receive rehabilitation services. But, when older workers are provided with rehabilitation, they are more likely to return to work than younger persons. (This is likely the result of substantial screening where only older persons with the highest rehabilitation potential are accepted for rehabilitation services) (Hester, 1986).

In fact, there is a paradox related to older workers with a disability — they comprise the majority of persons returning to work after experiencing a disability and they also represent the overwhelming majority of those who reach retirement age without returning to work. Part of the reason for this paradox is the complex set of relationships (still not well understood) between age, health and labor force participation. What little research we have indicates that: disabling impairments affect labor force participation decisions of substantial numbers of older workers; partial disability (i.e., impairments which exist but often do not significantly or totally reduce work capacity) is a very common occurrence; and labor market factors affect employment decisions. From a public policy perspective therefore promoting continued employment among older workers with disabilities would require more realistic standards for: (1) measuring impairments, (2) establishing functional performance criteria which reflect job requirements; and (3) modifying income support programs to provide financial incentives for continued employment (Morrison, 1986). But, even if public policies were changed to provide more incentives for employment, legal protection and changes in employer attitudes concerning older workers and older workers with disabilities are needed to create any meaningful increase in employment opportunities.

Extent of Problem

In enacting the ADA Congress found that:

- 43 million Americans have one or more physical or mental disabilities and the number is increasing as the population ages.
- About 73 percent of these individuals want to work but have not been able to find jobs.
- Society has isolated and segregated people with disabilities and discrimination against them is a serious and pervasive problem.
- Discrimination against people with disabilities continues in employment, housing, public accommodations, education, transportation, communication, health services, voting, access to public services, etc.
- Unlike persons experiencing discrimination on the basis of race, sex, religion, national origin or age, persons with disabilities have had no legal method to address such discrimination.
- Individuals with disabilities continually encounter discrimination including outright exclusion and discriminatory effects of architectural, transportation and communication barriers, overprotective rules and policies, exclusionary qualification standards and criteria, segregation and relegation to lesser services, etc.
- Polls and studies indicate that people with disabilities, as a group, occupy an inferior status in society and are severely disadvantaged socially, vocationally, economically and educationally.
- Individuals with disabilities are a discrete minority faced with restrictions and limitations, subjected to a history of purposeful unequal treatment and relegated to political powerlessness based on characteristics beyond their control and resulting from stereotypical assumptions not indicative of the ability of such individuals to participate in and contribute to society.
- The continuing existence of unfair discrimination deprives people with disabilities the opportunity to compete on an equal basis and pursue opportunities freely and costs the United States billions of dollars in unnecessary expenses resulting from dependency and being non-productive.
- The nation's goals for people with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency.

The complex problems faced by older disabled persons represent a combination of discrimination, isolation, exclusion and the effects of impairments that older persons often experience. Decisions to leave employment are therefore influenced by multiple factors, many of which are not easily quantified. Clearly, health problems, reductions in functional capacity, limitations in employer accommodations and availability of income and health insurance benefits all affect worker "choices."

Discrimination in employment based on age and disability is very widespread (Myers, 1981). Because of assumptions made about the supposed declining capacities of older workers, their skill obsolescence, difficulties in training and limited success in responding to vocational rehabilitation services, older disabled persons continue to receive only limited assistance from employers and the rehabilitation system as a whole. And, even though the actual functional and intellectual capacities of older persons have been shown to remain quite intact in terms of work performance, (Meyers, 1984) these findings have had almost no effect on employers' decisions to hire or retain older workers. A major problem appears to be that negative attitudes lead to discriminatory employment practices. This negativity is reflected in the widely held opinion that "it is easier to encourage the older

disabled worker to retire on disability since he/she really doesn't want to work anyway."

Attitudes About Older Workers— Some Contradictions

Research has shown that (AARP, 1986a):

- Productivity does not decline with age.
- Workers age 45 and older have attendance equal to or better than other age groups.
- Employees between ages 50-60 have been with their organizations an average of 15 years.
- The age of candidates for top level positions has been increasing.
- Age alone is a poor indicator of health or functional performance.
- Older managers are capable decision-makers.
- Intelligence remains constant through age 70.
- Age related declines in memory are slight and have little effect on performance.
- People who are capable of learning when young and who continually use these skills can maintain the ability to learn when older.
- Accidents at work are few for older employees.
- Forty-three percent of older workers state a preference for retiring at or above 65.
- Most older workers (79 percent) believe employers discriminate against older people.

Employers themselves share many positive views about older employees but also hold certain negative perceptions (information is not available about employer attitudes concerning older persons with disabilities) (AARP, 1986b): Older employers demonstrate:

Positive Views	***Negative Views***
Good attendance/punctuality	Lack of flexibility
Commitment to quality	Difficulty with new technologies
Loyalty	Physical limitations
Practical Knowledge	Learning new skills quickly
Experience	Competitiveness
Performance	Creativity
Ability	Individual initiative

These attitudes become very important in light of several major priorities of nearly all employers — productivity, cost of health insurance and introduction of new technology. So far as productivity (and quality) are concerned, employers in general have no difficulty in recognizing older workers as meeting these standards. And, when health insurance is considered alone, most employers do not perceive the cost of older workers to be a problem. Most say that any extra cost of health insurance is insignificant in comparison to total company health care costs. However, when costs for total compensation are considered, it is clear that many large firms believe that older workers are much more expensive than younger employees and thus support early retirement incentive programs (Morrison, 1990). When it comes to new technologies, nearly all organizations believe that older workers are less comfortable and have more difficulty in learning and adjusting than younger (and more recently trained) employees. The extent to which this issue affects older worker retention and hiring will vary depending on the importance of technology to the firm and the number of older workers in the organization.

Perhaps the most important underlying attitudinal barriers, however, are in areas that are very difficult to quantify or evaluate in terms of employer decisions, but may be crucial so far as resistance to older workers is concerned. It turns out that some of the greatest differences between issues that employers consider important and their perceptions of older worker capabilities are in flexibility to perform different tasks, ability to learn new skills quickly, individual initiative, and creativity. Employers perceive older workers to have limited ability in these areas. Irrespective of their accuracy, these negative views must be addressed if older employees and particularly those with disabilities are to become more valued by employers.

On balance, labor force trends such as slower growth of the young workforce, increasing labor force diversity and the shift to service jobs may lead to some increase in demand for older workers who have impairments. Yet, growth in technology, reductions in middle management, increasing health costs, and, perhaps most importantly, negative attitudes about older persons' capability to adjust to new workplace demands, learn new skills and be competitive, will result in limiting opportunities for the older "disabled" worker. This means that some exceptional approaches will be needed if older workers with impairments are going to have any significant chance to be employed.

Barriers to Rehabilitation

In addition to attitudes of employers leading to discrimination in retention, new hiring, health screening requirements, lack of employee accommodations, etc., there are other serious barriers for older workers with impairments. Some of the most important of these are:

- Internalization of negative beliefs by older persons with impairments themselves, leading to negative self-worth and lack of motivation to seek or obtain employment.
- Negative attitudes held by professional counselors/rehabilitation placement specialists leading to reduced service provision for the older impaired worker even though counseling, individualized job development and placement have proven highly effective for older workers.
- "Uncoordinated" federal policies which in effect contradict the objective of employment for older workers (such as Social Security earnings limits, relatively low Social Security benefit adjustments for working after age 65, limited and ambiguous work incentives in the Social Security disability insurance program, poor enforcement of age discrimination in employment laws, etc.).
- Lack of independent living programs and services to enable older persons with disabilities to make their own choices about health, housing, employment, leisure and recreation, etc.
- Lack of federal and state legislation specifically identifying older persons with disabilities for protection and service delivery.
- Proliferation of early retirement programs and total disability retirement programs.

All of these barriers place the older person with a disability at a tremendous disadvantage in the labor market. Employer

attitudes, older worker perceptions and beliefs and government policies provide very limited support for employing older impaired workers.

Overcoming Barriers: Multiple Responsibilities

Because the reasons for work disability and cessation of work are complex, there is no simple prescription which can quickly result in major improvements in the employment of older workers with impairments. And, while we could seek to identify every specific problem leading to lack of employment opportunity, and develop multi-part solutions for each problem, resources to achieve all these "solutions" would never materialize. Therefore, the most practical approach is to identify the most important "intervention points" and develop major strategies which will, in effect, change policies and practices to create more employment opportunities. The two most important intervention areas are corporate human resource policies and government laws and regulatory policies.

Corporate Policies

When asked about the responsibility for providing older workers with assistance and more employment equity, 70 percent of corporations placed major responsibility on corporate policy, senior management and older workers themselves. Fewer (43 percent) suggested federal laws and regulations as being primarily responsible for assisting older workers (AARP, 1986b).

Corporations act on the basis of self-interest with strong beliefs in efficiency and cost-effectiveness. Corporate policy makers are well aware of the importance of attitudes, motivation and quality performance of their workforces. Competition, both national and international, has led to recognition of the significance of a quality workforce. Corporations also seek to avoid legal difficulties which are costly and damaging to the firm.

As it turns out, corporations are well aware of the costs of work disability and many are seeking to better control these costs through reducing work injury and trying to reduce long periods where employees do not work because of impairment severity. The major approach being taken by businesses is disability management which involves methods to rapidly and comprehensively assist workers who become impaired, including involving the worker directly in the restoration process. Basically, the process involves early intervention, evaluating the impaired employee, developing a plan with alternatives to use the employee's strengths, coordinating medical and vocational rehabilitation and making necessary worksite accommodations to assist return to work. While this "ideal' approach is not used widely at present, its components are well recognized and are be' g discussed and written about throughout the country.

Older impaired workers, who may experience chronic illnesses and impairments in particular, require appropriate management to prevent lengthy and costly disruptions of work. Sometimes, the actual impairment can be treated through medical rehabilitation and industrial rehabilitation services. But, employees end up staying out of work for long periods because of emotional or motivational problems which are not being managed. For older workers, chronic conditions can extend the period when employment cannot be performed. In many instances, the period out of work is longer than would be expected given the impairments involved. This frequently occurs when the individual is poorly motivated or faces psychological problems which are not addressed effectively. In addition, inadequate medical and vocational case management can produce this result.

While primary prevention of impairments is always the ultimate goal, it is recognized that *appropriate intervention* and *disability management* can substantially reduce the occurrence of "secondary disabilities" which can be very costly over long periods of time. Effective disability management depends on:

- Rapid response, initiating interventions as soon after occurrence of the impairment as possible.
- Comprehensive, ongoing evaluation to time interventions appropriately.
- Addressing medical, psychological and vocational issues.
- Self-determination by the employee, with individual planning.
- Balancing economic compensation with incentives to return to work.

To most effectively achieve continued employment for impaired workers, the organization's benefit plan, health intervention and job accommodation strategies must be known to management and the implementation approach, well understood. A flexible plan for responding to worker impairment episodes is critical if employees are to be retained. Also, for older workers, explicit recognition of the existence of disability retirement provisions of benefit plans *and continuing employment options*, is critical if these employees are to consider remaining at work. Finally, managers must recognize that timely medical care, rehabilitation, assessment of capability for work, and providing a *range of employment alternatives* for older employment are all necessary if the goal of continued work for persons with disabilities is to be achieved.

Maintaining employment for persons with severe disabilities often requires continued prevention and medical management programs so that the employee can receive appropriate medical and non-medical services timely. An effective disability management program requires an organized corporate approach *with work incentives* which are understood by line managers.

It is always acknowledged that business organizations control the entry or return to employment for workers with disabilities. To fulfill their *recognized* responsibility for providing assistance to older workers with disabilities, organizations need flexible disability management policies. These differ from claims management, health insurance benefits or vocational rehabilitation approaches which are typically based on the "medical model" of acute intervention leading to "cure". Disability management is essentially based on information leading to appropriate and timely intervention across medical, psychological and vocational lines. The employee, employer and rehabilitation providers must coordinate their efforts for disability management to be effective.

In overcoming attitudinal barriers toward older workers with disabilities, an effective disability management program or, alternatively, appropriate policies and steps to sensibly assist workers to retain employment, is more important than direct attempts to quickly change attitudes and behaviors by informa-

tion and/or data alone. Placing the return to work of disabled employees in a management performance context, based on both financial and human resource advantages to the organization, will lead to attitude change and to the employment of more older workers with disabilities.

Laws and Regulatory Policies

Disability management policies, if developed and implemented, can result in reducing barriers to employment for older workers with disabilities. But, progress is likely to be quite slow and many smaller organizations may not be able to justify staff time to develop, implement and monitor disability management. A more general set of standards which establishes legally required protections clearly can have faster and more far reaching effects in improving opportunities for employment of persons with disabilities.

Civil rights laws often do not directly lead to more jobs for protected classes of the population. Rather, these laws (and their regulations) lead to changes in organizational policies which previously excluded persons from competing for opportunities. Once exclusionary policies change, this leads directly to access by the protected group to compete for jobs that were previously unavailable to them.

Thus, the Americans with Disabilities Act has as its purposes:

- To provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities
- To provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities
- To ensure that the federal government plays a central role in enforcing the standards established on behalf of individuals with disabilities; and
- To invoke the sweep of congressional authority, including the power to enforce the Fourteenth Amendment and to regulate commerce, in order to address the major areas of discrimination faced day to day by people with disabilities.

Title I of the Americans with Disabilities Act specifies that any employer, employment agency, labor organization or joint labor/management committee may not discriminate against a qualified person with a disability in regard to any term, condition, or privilege of employment. Based on standards established in the regulations implementing Section 504 of the Rehabilitation Act, the ADA provides that any person with a disability cannot be denied a job on the basis of disability if they can perform *the essential functions of that job.* ADA requires that employers must make a reasonable accommodation for those individuals unless such an accommodation would result in an undue hardship for the business or entity covered.

The term "qualified individual with a disability" means an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires. For purposes of this title, consideration shall be given to the employer's judgment as to what functions of a job are essential, and if an employer has prepared a written description before advertising or interviewing applicants for the job, this description shall be considered evidence of the essential functions of the job.

The term "reasonable accommodation" may include (a) making existing facilities used by employees readily accessible to and usable by individuals with disabilities and; (b) job restructuring, part-time or modified work schedules, reassignment to a vacant position, acquisition or modification of equipment or devices, appropriate adjustment or modifications of examinations, training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities.

The legal obligation of an entity to provide such an accommodation depends on whether the accommodation would impose an undue hardship on the entity covered. Reasonable accommodations should be tailored to the individual needs of the person with the disability in relation to that specific job. The person with the disability should be consulted as to what accommodations they require in order to do the job. Employers should not simply assume that certain accommodations are required for an individual. The employer must notify applicants and employees of its obligation under the Act to make reasonable accommodations. The law also requires that reasonable accommodations be made for "an otherwise qualified individual who is an applicant or employee...." The term otherwise qualified is used in this particular provision in order to clearly describe a person with a disability who meets all of the employer's job related selection criteria except those criteria that he or she cannot meet because of the disability, but which could be met with a reasonable accommodation. The individual, who is "otherwise qualified" for the job, must then be offered the reasonable accommodation that will then make the individual a "qualified individual with a disability" under this title.

In addition, the law clearly states that employers are obligated to make reasonable accommodations only to the "known" physical or mental limitations of an otherwise qualified individual with a disability. Thus the duty to accommodate is generally triggered by a request from an applicant for employment or an employee. Of course, if a person with a known disability is having difficulty performing his or her job, it would be permissible for the employer to discuss the possibility of providing a reasonable accommodation for the employee. Finally, implementation of the accommodation should not impose an undue hardship on the employer's operation.

The enactment of these provisions in the ADA (and the accompanying regulations further defining the provisions, soon to be promulgated) establishes for the first time, legally enforceable protection against discrimination for persons with disabilities. These standards will operate both as *guidelines* for organization policies related to hiring and retaining workers with disabilities and as *legal protections* in the event that discriminatory practices may occur. Because of this law, most U.S. businesses will be required to open up competition for jobs to all qualified applicants irrespective of their impairments or disabilities. Moreover, they will be required to provide (usually inexpensive) reasonable accommodations so that qualified workers who may have disabilities can perform their jobs. This type of governmental legislative action also leads to overcoming serious barriers to opportunities for all persons with disabilities. Because of this law, it is no longer possible to defend prior discrimination and exclusion of persons with disabilities from the workforce. The gradual elimination of exclusion will have the additional

consequence of reducing negative attitudes and perceptions about persons with disabilities. Again in this case, the appropriate approach is to create the legal mandate that will lead to change rather than to attempt to abruptly alter organizational behavior by means of a simple demand for change.

Conclusion

Despite increasing reports about the productive capacity of older workers, their good work habits, loyalty and ability to learn new technologies, their labor force participation has not significantly increased. This is primarily because of the availability of early retirement options and limitations in flexible work options provided by employers which are attractive to the subset of older persons who might work. Attitudinal barriers exist, as does age discrimination, but these are not the only or the major reasons for declining labor force participation.

Since age is often associated with increasing chance of impairment and disability, a higher proportion of older employees become disabled than other age groups. This creates a situation of "double jeopardy" for older impaired workers which has often been discussed. The problem that exists for the older worker with a disability is in effect a combination of negative attitudes about both age and disability along with strong incentives to leave employment and collect disability income benefits from the organization and the government. The problem is compounded by the extremely limited hiring of persons with disabilities, especially older workers.

Solving this problem requires both short and long-term approaches. In the short-term, the most practical approach may be a combination of education about the capabilities of older workers (both with and without disabilities) combined with employer disability management approaches. For this to be effective, attention must be given to providing reasonable accommodations for workers with disabilities, flexible work schedules and training in new technologies where needed. Also, to an extent, organizations' hiring pools must be expanded to include more older workers, and those with disabilities. This means that organizations will have to coordinate more closely with rehabilitation facilities which provide health and vocational services. These steps are by no means easy to accomplish in today's business environment, but they are feasible and involve few extra costs to organizations.

In the long run, if *major changes* are to occur in employer hiring and retention of older workers with disabilities, the behavior of health care professionals, employers and rehabilitation providers will have to change, as will government policies.

First, and perhaps foremost, health care providers will have to consider older persons with impairments holistically and evaluate functional capacities in terms of continued employment potential. Second, employers and rehabilitation providers will have to respond pro-actively to the provisions of the ADA in terms of opening-up job opportunities to persons with disabilities, designing and providing reasonable accommodations and evaluating job applicants in terms of their ability to perform essential job functions. And, employers will have to adopt disability management approaches to reduce disability compensation costs and increase worker productivity. Finally, in addition to the ADA, government policies which now establish rigid barriers to access disability benefits and then provide ambiguous and inconsistent "incentives" to return to work will have to change so that a comprehensive rehabilitation policy can emerge *linked to the health care system* and vocational placement system rather than the income maintenance system. Use of medical and vocational rehabilitation facilities must be a fundamental part of this policy.

To accomplish these changes requires both attitudinal change and a positive response to the legal protections of the ADA. Work disability in the United States is most often a problem for the older person who has invested a lifetime in a work career. It is tragic that most employer incentives now result in older workers with disabilities permanently leaving the labor force. Government programs based almost entirely on income maintenance become the last resort of these formerly productive persons. The fiscal burdens and personal human consequences of these policies are negative and need to be changed. For this to occur, the legal protections of the ADA and the ADEA will have to be linked to attitude changes and new policies of employers which emphasize maintaining employee productivity.

References

American Association of Retired Persons "Workers 45+: Today and Tomorrow." AARP Worker Equity, Washington, D.C., 1986(a).

American Association of Retired Persons. "Workers over 50: Old Myths, New Realities." AARP Worker Equity, Washington, D.C., 1986(b).

Fullerton, H.N. Jr. "New Labor Force Projections Spanning 1988 to 2000." *Monthly Labor Review*, 112, November, 1989.

Hester, E.J. "The Need for Rehabilitation Services Among Older Workers." Eleventh Switzer Memorial Seminar: The Aging Workforce: Implications for Rehabilitation. The Menninger Foundation, Topeka, Kansas, October, 1986.

Meyers, J.E. "Rehabilitation of Older People" *Annual Review of Rehabilitation*, 1984.

Meyers, J.E., (Ed.) "Rehabilitation of Older Persons." *Journal of Rehabilitation*, 47(4), 1981.

Morrison, M.H. "A New Look at Corporate Costs for Early Retirement: Retaining vs. Retiring Older Workers." National Foundation for Occupational and Environmental Health Research, Washington, D.C., May, 1990.

Morrison, M.H. "Structural Issues in Employment of Older Persons: Interaction between Health and Retirement." Eleventh Switzer Memorial Seminar: The Aging Workforce: Implications for Rehabilitation. Washington, D.C., 1986.

Rix, Sara E. "America's Aging Workforce" *Issue Brief*, AARP Public Policy Institute, March, 1991.

Schulz, James H. "Job Matching in an Aging Society: Barriers to the Utilization of Older Workers. Paper presented at Annual Meeting of the Gerontological Society of America, San Francisco, California, November, 1988.

U.S. Bureau of Labor Statistics, *Employment and Earnings*. Washington, D.C.: U.S. Government Printing Office, January, 1986.

U.S. Bureau of Labor Statistics, *Handbook of Labor Statistics*. Washington, D.C.: U.S. Government Printing Office, June, 1985.

Excerpts of Reviews and Comments

The importance of legal protections and changes in attitude are the recurring themes in *Employment of Older Workers with a Disability: Attitudes and Legal Issues*. The themes provides a focus for our examinations of the ADA as it applies to older workers with disabilities—"How can using the ADA effectuate changes in behavior and attitudes leading to policies that provide job opportunities for people with disabilities?"

The paradox that describes older workers with a disability is that they comprise the majority of persons returning to work after experiencing disability; and yet, they also represent the majority of those who reach retirement age without returning to work. Dr. Morrison briefly outlines what public policy changes are necessary to affect the decision to stay employed. He then returns to his theme and shows that even if policies were changed to provide more incentives for employment, legal protections and attitude changes would still be necessary.

Dr. Morrison asserts that exceptional approaches will be needed.

This assertion is a most practical and refreshing one. The tremendous hurdles are listed and difficulties are acknowledged—this is a paper that faces full-on the realities of age plus disability and approaches the problem from a "what is possible," stance.

Two "intervention points" are identified. These are the points where strategies to change policies and practices and thus create more employment opportunities should be developed. They are:

- corporate human resource policies,
- law and regulatory policies.

Dr. Morrison's approach to policies is one of ultimate practicality, "...based on both financial and human resource advantages to the organization will lead to attitude change...".

This paper is bold because it tosses into the ring the assertion— the civil rights principle— that legal standards carry much more immediate clout than "vague" policies. Given continuing debates about what was intended by the Social Security amendments requiring continuing disability reviews, what the following regulations required and what "vague policy" drove those actions, to assume the ADA as law, will carry the clout we expect requires a lot of faith.

Dr. Morrison's paper whets the appetite for future research that tracks the court cases and the decisions, and draws some further conclusions about legal protections and attitudes as they relate to the passage of the ADA.

—Laurel Beedon

Morrison outlines a cogent presentation of the multiple problems faced by the older worker. The paper stresses the fact that the complex relationships between age, health, and labor force participation is "still not-well understood." Still, two basic issues are highlighted. Disability or disabling impairments affect labor force participation, along with labor market factors and negative attitudes lead directly to discriminatory employment practices. Morrison moves on to tackle the often cited cliche that "one cannot legislate attitudes" by an attempt to link positive change of attitudes through laws and regulatory practice such as the Americans with Disabilities Act (ADA). The jury may be still out but the argument is persuasive. As Morrison points out very early in the paper, civil rights legislation has "resulted in less discrimination behavior."

One element which may be the most critical for the employment of the older worker was brought up but not really followed through in the rest of the text. There is a need for "more realistic standards for measuring impairments, establishing functional performance criteria which reflect job requirements and modifications to income support programs to provide financial incentives." Some work has begun with regard to exploring the incentive questions, but little has occurred with standards and performance criteria. Perhaps some of the negative attitudes emanating from both employers, as well as the older worker, come from a lack of criteria by which one measures what one is able to do. The burden is upon rehabilitation, both public and private, to research and to develop better assessments that have validity and meaning for the workplace.

The other primary emphasis on the ADA is a timely one with the regulations just beginning to appear. Undoubtedly, ADA is landmark legislation and moves persons with disabilities into the mainstream as never in this country's history. The impact, however, will only be as strong as persons with disabilities and their advocates make it. Finally, it must be a cooperative effort rather than an adversarial one for ADA to succeed in the long run.

—Paul Leung

This paper is well written with a clear and complete analysis of ADA. The interesting introduction hypothesis that behavioral change will change attitudes, sets the stage for "hope" in the years to come.

It is important to point out that eligibility for rehabilitation is the same for any age, and "employability" (or "potential" as used by the author) is one of the three criteria of eligibility for rehabilitation services from any state vocational rehabilitation agency. Clients are eligible if they have a documented disability that is vocationally handicapping, and no age or disability group are required to have only the "highest rehabilitation potential". For the most part, elderly receiving rehabilitation services have better current training and support services to eventually help them enter the job market because of the rehabilitation services received.

It can be assumed then that elderly disabled that do not receive rehabilitation services may not be employable. The economy in the 21st Century will be information based, offices may well be in a briefcase, and small companies will increase. The aging population will be the fastest growing group in our society and the economy will need workers. The elderly are a natural group to help meet this need.

The final pages of this position paper clearly states the need for legislative changes that tie incentives for working to

health needs, as well as income needs. Development of this concept holds much promise.

—Judy Ann Buffmire

As the author correctly points out, the Americans with Disabilities Act will not create new jobs in America. But it will go far in changing behavior and raising awareness in our society concerning disability issues.

The author stresses the importance of policies that provide job opportunities for people with disabilities. I agree that policies are important, but the bulk of large employers already have such policies in place and are already taking affirmative action in accordance with the Rehabilitation Act of 1973.

What is powerful about the Americans with Disabilities Act is that it reaches the small employer and the large employer alike and does not depend on federal contractor status to make the connection.

Educational efforts concerning legal requirements under the ADA should especially be focused on smaller employers. Smaller employers provide the majority of job opportunities in America and are now, many of them for the first time, faced with a federal legal obligation concerning people with disabilities. In addition, smaller employers especially need education about the services available through public sector and non-profit sector agencies and how they can partner with these agencies and with rehabilitation professionals to provide employment opportunities for qualified older workers with disabilities, in particular.

—Linda I. Workman

Each of the "barriers to rehabilitation" identified in this article has its own implications for actions to be taken. Corporate policies, laws and government regulatory policies (and practices) are emphasized as keys to substantial increases in access to employment for older disabled persons. While the implementation of better disability management, as an example, depends in part on attitudinal changes, such programs can in turn lead to more substantial attitudinal changes based on experience and new understandings. The Americans with Disabilities Act should be an effective catalyst for an improved interaction between corporate self interest, changes in employer practices and attitudes regarding the employment of older person with disabilities.

It is made apparent in this article that various factors such as social security policies, employer perceptions, attitudes among professionals and the internalization of ageist beliefs by older persons themselves, interact in ways which tend to maintain the problem of under employment. It is also apparent that improved employment for older disabled persons will require a multifaceted approach.

Federal policies which discourage employment (Social Security earnings penalties for employment, low benefits adjustments for employment beyond age 65 etc.) seem counterproductive and should be reviewed in relation to their impact on the individual and national interests. Establishing means tests for Social Security, as is sometimes considered, would probably encourage earlier and permanent exit from the labor force. Employer practices do not always reflect an enlightened self interest. Guides to best practices should be helpful.

The qualifications of professionals who work with older persons is an issue both in relation to their attitudes and the adequacy of their preparation. The means must be established for assuring the presence of professionals who are specifically prepared for work with older persons in the rehabilitation, health care and counseling services.

Not working may sometimes have little to do with a disability, but much to do with a work atmosphere that is or is not characterized by congeniality, physical and emotional safety and respect. People sometimes want to escape their jobs, and find health problems a socially acceptable reason for early retirement. In some instances, the changes that are needed to keep older persons in the work force relate to basic employer-employee relationships and making employment more attractive than aversive.

—Richard Blake

Dr. Morrison's paper is very well written and his expertise in the areas of aging and disability are obvious.

Many of the problems identified regarding the service to SSI (Supplemental Security Income) and SSDI (Social Security Disability Insurance) recipients by VR (Vocational Rehabilitation) programs could easily be resolved by merely changing the length of time from nine months to two months for a "successful placement" qualifying VR for reimbursement for case related expenses by SSA (Social Security Administration). The burden of having to track individuals for the seven months more than the typical VR client, in addition to the cost of requesting expenses, make it not worth the effort as decided by several state agencies. There would not be any need for SSA to revise any of their other policies or programs and the funds collected would still be limited to those individuals who were SSI and/or SSDI recipients. This would also give a more accurate picture of the ability of VR to train and place SSA clients.

Dr. Morrison's paper points out many of the problems faced by people with disabilities. It points to the need for a change in how we approach the subject of disability. There is discussion about financial disincentives to work when in fact the current federal SSA, housing, and rehabilitation programs are set up to eliminate the disincentives. What is needed is the tying together of resources and education to service providers and individuals with disabilities as to how to orchestrate the support/recovery process.

The section on attitudes about older workers and positive and negative views identifies the dilemma of these people when dealing with business. Dr. Morrison shows the importance of the education of rehabilitation professionals, in addition to business and society in order to allow their attitudes to reflect the numerous talents and potential of older workers. Education with appropriate disability management will address many of the identified problems.

When considering the length of stay away from a worksite in worker compensation cases, it is important to consider the role of the worker's attorney. Although after as large a settlement as possible, ostensively for the worker, the separation from the job site may play greater damage to the individual's and company's percep-

tion of future employability. The negative psychological impact, in my estimation, will weigh far greater than a modest short-term financial gain.

By reading this paper, I considered for the first time that the baby-boom generation was going to have dramatic influence of elder issues. First, the baby-boom generation is pushing their parents out of the workforce due to their numbers while at the same time due to the delay in having children, the generation will not face similar pressure. Second, as the baby-boom generation realizes this, two things will happen: they will take care of their parents legislatively and they will take care of themselves. Finally, just as it was glamorous to be a teenager in the fifties and sixties, it is glamorous to be middle-aged now, I predict that it will be glamorous to be an older person in ten to twenty years. *(The opinions expressed are those of the author and not official RSA positions.)*

—John Nelson

It is imperative that people who experience limitations of activity due to late onset of disability know that the ultimate result does not have to be excessive dependence. People with disabilities involved with Independent Living Centers (ILCs) can teach others prior to or soon after they acquire a disability that they can continue to live and work with a disability.

America's human service systems, including rehabilitation, do not view older people as rehabilitatable. The field of rehabilitation has put little effort into looking at older people and how their independence and their ability to live and work with a disability might be maximized.

Many individuals with later onset of disability are identified as ill, sick, infirm, or invalid. They are expected to lose their independence if they acquire a disability. Their independent living options are not explored.

ILCs in this country help people with disabilities achieve or maintain independent and productive lives in their community.

People with disabilities are assisted in exploring and choosing alternatives to institutionalization. Through flexible assistance, advocacy and services individuals are encouraged to make their own decisions about how they will live. ILCs directly provide, and coordinate through referral, services which assist people in increasing their ability to exercise control over their lives. This means having a choice of acceptable options in making decisions and performing everyday activities and includes managing one's own affairs, participating in day-to-day community life, and fulfilling a range of social roles.

Expectations and Attitudes

People who experience a late onset of disability frequently take a very fatalistic and passive approach toward an acquired disability. Disability is thought of as a disengagement from common life activities, of approaching the end, and sometimes as an accelerated course toward death. Disability is not dealt with as coping with a new and different challenge.

People who experience a late onset of disability expect reduced functioning as a result of aging and are often passive when it comes to seeking any type of rehabilitation assistance. In contrast, people with disabilities active in the Independent Living (IL) movement develop an assertive approach toward coping with disability, an approach viewed as an important survival skill. Independent living is highly valued, fought for and risks to maintain or achieve independence are encouraged.

Incontinence, for example, can often seem like the end of the world for those experiencing later onset of disability (late onsetters). Younger people view the same situation as a problem, but they eventually take a "let's deal with it and get on with living" attitude. Transitioning from walking to using a wheelchair or other mobility aid is accompanied by emotional reactions of loss for both groups. People involved with the IL movement, however, eventually come to value the increased mobility that these aids or wheelchair use offer, while for older people it represents just another loss, and only a loss!

Negative Stereotypes

Due to the frightening and negative feelings toward disability that permeate society, it is often too threatening and painful for an older person to admit to having a disability. Thus, you often hear an older person say: "I'm not blind, I just have trouble seeing," "I'm not deaf, I just have a little trouble hearing," or "It's not that I can't walk, it's just that I get tired and it's easier to use a wheelchair."

People with disabilities and seniors are victims of severe stereotyping. For every devaluative stereotype related to aging there are two related to disability! Hence the underlying attitude, "I might be old, but don't ask me to acknowledge that I have a disability, too!" Disability stereotypes in our society consist of images of people who are burdens, asexual, child-like, unproductive, bitter, depressed, deformed, marked and victims, to name only a few.

Because both groups are so devalued by "ageist" and "handicapist" attitudes, it makes psychological sense that older people with disabilities do not want to take on the additional burden of being viewed in the same way that society views peoples with disabilities. The devaluations are very similar and "one dose" is enough!

Disability Pride

For people with disabilities involved in the IL movement, the emphasis is on coping, independence, adapting and working. This focus often provides the necessary resources and survival skills for more successful coping with disability as one ages. For example, through involvement with the IL movement or through the challenges involved in growing up with a disability, or both, most people learn to eventually give up attempts at "passing." "Acting as if" one's disability does not exist, denying its existence or just concealing it is "passing." "Passing" behavior can lead to persistent and exaggerated feelings of failure and inferiority, not to mention the tremendous amount of energy involved in acting as if one's disability did not exist. Instead of concealing disability, the IL movement has promoted a type of "disability pride," a positive identification with disability.

The message is that: One does not have to be ashamed of or embarrassed about a disability. This positive identification has mitigated the devastating effects that societal disability-related stereotypes can have on an individual's self image.

A Different View

It is the built environment that is often the real disability. The built environment limits participation, productivity, integration, independence and equality. If a person with a disability is offered a job that

cannot be accepted because it is located on the second floor of a building without an elevator, the real disability is that there is no elevator. When a person cannot attend school or a training program because there are no ramps or curb cuts, the real disability is that there is no physical access to the program.

People involved in the IL movement typically challenged the medical model, because the medical world tends to bestow on people with disabilities a life-long "sick" devalued, inferior role. Just because people with disabilities are not "curable" does not mean they must take on the life-long "sick" role. A role that connotes individuals are:

- exempt from regular responsibilities and social activities
- exempt from any responsibility for their self-care, evaluating information and making decisions
- obliged to accept society's definition of the state of being sick as not desirable.

In the IL model people with disabilities do not view themselves as ill. There is no cause and effect relationship between disability and illness. The two are not synonymous.

In the IL movement, people with disabilities' role in self-care is key and the authoritarian role of the physician in diagnosis and treatment is deemphasized! There is a healthy distrust that medical providers always know best. The IL movement has challenged doctors and other health care professionals who have a tendency to be dogmatically prescriptive and judgmental in telling people with disabilities what to do and how to live their lives.

Pre-ILC History

Before ILCs existed the prevalence of the medical model was, and to a large part still is, responsible for the institutionalization of many individuals with disabilities. The independent living movement sees these people not as sick, but as needing non-medical community-based independent living support services.

IL movement activists cringe at being called "patients." "Patients" connote people sitting or lying passively or patiently waiting for something to be done to them. People who have disabilities are not chronic patients.

The focus of the IL approach is coping and maximizing or maintaining function. The focus is not on cure. This focus calls for creativity and flexibility and often incorporates very unorthodox strategies and risk taking approaches that work for people. These approaches are often seen as "not right" or "unacceptable" by medical professionals.

The low-functional expectations of people who experience a late onset of disability may be a result of a lifetime of relatively passive adherence to physicians' directives. Independent living people whose disability had an early onset learned long ago to question, modify and sometimes ignore these directives.

The IL Approach

"The IL approach is one of empowerment— a consumer-oriented model that comprises elements of social (vs. medical), independent (vs. dependent), active (vs. passive) participation and recipient (vs. provider) power." (16-4)

"ILCs teach people with disabilities how to access needed services and how to be their own service coordinators. The more traditional human service community would say how to be their own case managers." People learn accessing services and survival skills that they will have to use for the rest of their lives.

The goal is to enable people with disabilities to see themselves as participants in and controllers of social services rather than clients" or "patients."

The emphasis is on self-direction and control in contrast to the more traditional model in which the "client/patient" is highly dependent on experts. Service coordination is the individual's responsibility and is performed by the individual to the greatest extent possible. The ILC's role is to provide training until the people becomes self-reliant. People are not labeled "cases" to be managed as in "case management." They are people to be empowered to oversee their own service acquisition and coordination. (Options 9/86)

This approach is in contrast to more traditional approaches where services are assessed and prescribed for clients by their "case managers." The control over services rests with providers (third-party payers and medical and allied professionals).

In summary, from an educational, attitudinal and advocacy perspective the older worker, and more broadly the older person who ages into disability, as well as society in general can benefit from exposure to how the independent living movement views and copes with disability, and interacts with service and health care providers.

—June Isaacson Kailes

Chapter Four

Toward Employer Flexibility Through the Employee Life Cycle: The Case for the Older Worker

Paul E. Rupert

The American workplace is undergoing profound and disturbing changes. Some trends, like corporate downsizing and flexible staffing, are structural and, therefore, irreversible. Others, like early retirement and rigid scheduling, are programmatic, and thus open to change. All of these tendencies have had significant effects on older workers and will continue to do so throughout this decade.

Whether these effects prove more positive than negative in the long run will be a question of design—the design of private employment policy and of relevant public policy. Unfortunately, much of current policy in this area is less designed than hastily improvised. The dramatic growth of today's so-called contingent workforce is a good example. Born in the crucible of intense global competition, heralded as a weapon in the battle for improved productivity, this explosive trend bears no designer label, and shows a lack of forethought that should trouble anyone concerned about our long-term productivity.

There have always been "contingent workers" in the American workplace. Although the term was coined fairly recently by the Conference Board's Audrey Freedman to refer to the growing use of part-time, temporary and independently-contracted workers, the factories, fields and offices of America have routinely included hourly day-laborers, part-timers, temps and project-length staff.

The significance of this new phenomenon has been in its rapid growth, in its penetration of new sectors of the workforce and in the strategic use of these forms to strip the benefits from positions and thus cut costs. Indeed, this practice is often referred to as a core-ring strategy—the development of a "ring" of contingent workers to serve as a buffer for the "core" of regular, full-time employees in the event of downturn, etc. A further significance of this trend may lie in what it portends for the health insurance, pension and other benefits coverage of ALL "regular" employees over time.

PAUL E. RUPERT is Associate Director, New Ways to Work, San Francisco, California.

The title of this article describes a choice between contingency and equitable flexibility for older workers. What exactly, then, are the conditions of work for contingent workers? And how many of them are older workers?

Contingent workers include a wide array of staffing options and a host of compensation packages. The "snapshot" phrase that captures the phenomenon, though, is "part-time, temporary and contract workers with typically lower wages and fewer or no benefits." Before detailing the parts of this growing phenomenon, it is necessary to point out that most of the useful and relevant social data that we might want on any of these work forms *is not collected in any comprehensive, systematic manner*—and this does not allow us to target effective solutions to the problems raised. We can look later at why this is and what may be done. For the moment, it is enough to say that it constrains the portrait that follows.

The largest category of contingent workers is *part-timers*—some 19 million, according to the Bureau of Labor Statistics (BLS), in 1988.[1] The BLS breaks down these workers into two categories: so-called "voluntary" and "involuntary" part-timers. With part-timers defined as those working less than 35 hours, voluntaries are those who presumably want part-time work. The involuntary are those who would prefer to work full-time, but cannot find such work or have had their regular full-time hours reduced for "economic reasons".

While this is a useful distinction for capturing disguised underemployment, other descriptive pieces are sorely lacking. The most critical boundary for our purposes is between what's called "regular part-time" and "hourly part-time". Regular part-time work is usually described as less than full-time work by employees on a company's payroll. Ideally, such positions offer the same degree of job security and a *pro rata* share of the rights and benefits available to full-time workers.

Hourly part-timers are those who work less than full-time, who may or may not receive some pay premium in lieu of benefits and who do not receive any of the benefits accorded to regular employees. These workers typically have what's called

limited attachment to the firms. Often this means no job security at all, no training and no access to regular or full-time positions which might open up within the firm. We will return later to some of the productivity consequences of these proliferating positions.

The second most visible group of contingent workers are temporary workers numbering some 1.1 million in 1988. While this number is small, it is the 175% increase in this group since 1980 that has brought it to people's attention.[2] This total reflects almost exclusively temporary workers retained by firms from the familiar outside agencies, such as Kelly, Manpower, etc.

But the *faster growing* segment of temporaries is in fact workers recruited from an internal temporary pool administered by a company. (Many of these temporary pools began as so-called retiree job banks, aimed at bringing back early retirees who still had contributions to make to the firm, and turned over time into general temp pools open to new hires as well.) The current BLS data systems do not measure these temps in any systematic way, making accurate description of the phenomenon difficult.

The compensation and benefits packages of the range of temporary workers vary enormously. As a rule, employers pay no benefits for external hires—indeed, that is one of their great appeals. A growing number of the temporary agencies claim to offer health insurance and other benefit packages to their employees, but the qualifying standards are significant and frequently prohibitive, the "benefits" are frequently purchased at the worker's expense and disclosure of actual coverage rates is neither required nor common.

The internal temporary pools are less consistent. Since many began as retiree pools made up of older workers who "didn't need" health insurance or pension coverage, many still do not offer benefits to any of their temps. Others extend partial coverage to those who work beyond a given number of hours annually. Some split the package and offer the benefits other than health and pension, but again, since quantitative and qualitative data on a national level are so limited, we are reduced to the anecdotal and a few private surveys for information.

The last significant category of contingent workers is called independent contractors, independently contracted workers or contract workers—frequently referring to the same group and sometimes denoting a distinction known mostly to the speaker or writer. The essence of these positions, which we call contract workers for ease of use, is that the worker is retained on a contractual basis for a specific project or time-limited activity; and for purposes of the IRS and labor law, the worker is considered *self-employed* and not an employee of the firm in question.

The two extremes of this category are consultants and farmworkers. Without digressing into the whole issue of classification and misclassification, suffice it to say that the defining characteristic of this group is that, as non-employees of the company and of an agency as in the case of the temps, they receive neither the health, pension and related benefits nor the unemployment insurance and mandated benefits that others receive.

While this may not be problematic for the better paid and truly self-employed consultants that many companies retain, the profound growth in this category over the last decade has been in the lower end of the workforce. Hundreds of thousands of regular jobs have been replaced by contract positions which offer far less compensation and security. Again, it is a great statistical misfortune that these distinct classes of workers have been counted together and buried by our data system in the category of the "self-employed" along with millions of entrepreneurs, doctors, dentists and other professionals.

With this portrait as the "what" of contingent work, let's look at the "how many" and the "who". Rick Belous, Vice President of the National Planning Association, wrote an excellent book on this phenomenon called *The Contingent Economy*. I recommend it for a full and able discussion of the problem of accurately counting the number of contingent workers in the economy and their growth in the decade of the 1980s. Given the reality of confused and overlapping categories, he develops an upper and lower estimate and finds that the growth rate of the contingent workforce from 1980 to 1988 was between 20% and 28%. Using the lower figure, the contingent workforce would constitute about 25% of current workers. He concludes the discussion with the assertion:

Thus, no matter if the real size of the contingent workforce is closer to the lower or the upper boundary, we have strong grounds for asserting that:

- the contingent workforce is growing considerably faster than the entire workforce;
- close to one-fourth or more of the American labor force is now in the contingent workforce; and
- a significant number of the jobs generated in the 1980s have been for contingent workers.[3]

While it might seem that contingent positions were the crowning achievement of the "great American job machine" of the 1980s, is there any way to determine what is happening now and can we make any long-term projections? Hard numbers continue to be elusive. But two recent surveys of corporations offer some insight into the thinking of those who developed these strategies.

New Ways to Work initiated the first national survey of flexible scheduling and staffing in 1988. Sponsored by the Conference Board and conducted by Dr. Kathleen Christensen of the City University of New York, it examined employer usage of and satisfaction with a variety of flexible work arrangements, including part-time, contract workers, agency temps and internal temps.

Based on the survey sample of 521 companies, she concluded that these companies were planning a levelling off or at least a slowing in the rate of growth of their contingent workforces, with a shift toward greater use of flexible scheduling to achieve their flexibility needs. There was some indication of a desire to shift from use of agency temps to internal temps for greater efficiency and ease of supervision.[4] The difficulty of these two facts is that part-time work is included in her and their definition of flexible scheduling—meaning that the key issue becomes what kind of part-time work gets expanded. The problem with the turn to greater reliance on internal temporary pools is that these numbers evade counting. Thus any projected growth will prove hard to measure.

A more blunt assessment comes from the consulting firm Towers Perrin in a 1990 national survey called *Workforce 2000: Competing in a Seller's Market—is Corporate America Prepared?* This look at the human resource planning of 645 companies yielded the following trajectory for contingent work:

While 20% currently have a strategy in place to support development of a core work force with contingency workers, another 11% are working on plans for this sort of two-tier work force. [5]

While representing a small sample, this 11% is a disturbing number. If it did indeed represent the thinking of companies nationally, it would presage two things: 1) a slowing by half of the 1980s growth rate for contingent workers in the 1990s; but, 2) a potential real number increase of contingent jobs in the many millions in this decade.

Who have been and who will be these contingent jobholders? The hard data simply does not exist for a completely satisfactory answer. We can safely say that women, minorities, youth and older workers appear to be disproportionately represented among the contingent workforce. Various groups predominate in different categories.

For purposes of this paper, we will not dwell on the whole complex demographics, but look instead at the older worker. Older workers constitute a significant proportion of the enrollees in internal temporary pools—especially those which are or began as retiree job banks. Older women, and especially displaced homemakers, are also represented as re-entry workers in conventional temporary agencies. Similarly, many retirees return to work for their old employer or a similar firm on a contract basis. And finally, as one might expect in the largest category of the contingent workforce, older workers both seek and increasingly find themselves driven by economic necessity into the growing part-time workforce. The much-noticed McDonald's ads are not recruiting the older worker into core positions.

The numbers are unclear. But the anecdotal information from every source confirms the view that more and more older workers have found, and will find themselves—as marginal workers—forced into these second-tier jobs. Constant review of the business and human resource literature, discussions with business executives, and conversations with the research and program staff of older worker and other labor advocacy organizations yield this conclusion. The new census data and numerous studies underway will hopefully tell us more in the near term.

Meanwhile, if this contingent worklife is in the future of more older workers, what issues does it raise? And are there any reasonable alternatives to it?

The great value of these contingent options for both employers and employees is that they offer flexibility. The central question is: on what terms and for whose benefit is the flexibility provided? The push toward contingent or core-ring staffing has been coming from the employer side: it is driven by competition, the search for productivity gains and pressures to cut labor costs. The urge to cut costs best explains the reductions in wages, the stripping of benefits and the undoing of long-term commitments that characterize contingent work.

In some cases, the employees are not looking for open-ended jobs, the wages are acceptable and the benefits are unnecessary. This last is frequently cited as a reason why many older workers are ideal candidates for contingent jobs: they don't need health insurance or pensions. This repeated assertion among business people and within the policy community has taken on the universal quality of myth—and is likely just that. While it may be true that some older retirees with early claim on their pensions and company-provided health insurance do not need either—and perhaps any of the other benefits provided to regular employees—much of the older workforce needs the same things as other groups of workers. Without the normal trappings of regular work, their quality of life suffers.

It is not only the case that the conditions of individual workers deteriorate in contingent arrangements. This two-tier workforce can yield high turnover, greater absenteeism, stress-related illness, declining quality control—and ironically, a decrease in productivity in the long run. For the society there is the danger of a diminution of the skill level of the workforce as a whole when significant numbers of workers are shunted off into dead-end jobs and away from the normal on-the-job training programs that allow much of basic worker skill development. Further, when employment fails to cover the significant social safety net costs of health insurance and pension, a major burden is being shifted from the traditional employer provider to the individual and the society as a whole.

Contingent flexibility is too much a one-sided strategy. New Ways to Work thinks there is a better way that can benefit both employer and employee—and older workers in particular—as well as make a significant contribution to long-term productivity and competitiveness. We call this strategy *"EquiFlex"*, which is short for equitable flexibility. Our national project of that name advocates for change in private sector policy and practice and for public policy that can enhance such change.

New Ways to Work believes that equiflex offers a more effective form of workplace flexibility than contingency. We have based this design on the organization's 19 years of experience as the country's leading research, training and advocacy organization for flexible work arrangements. Simply put, we think that offering fair and flexible work options on a broad scale *throughout* a company makes better long-term business and social sense than retaining a rigid core and exporting discounted flexibility to the rings of part-timers, temps and contract workers.

Adopting this approach would be a profound change for employers to make. It requires not just a turn away from this recent infatuation with contingency. It also demands a re-examination of the structure of work time and schedules, the design of jobs and the nature of supervision. While much preliminary work in these areas is already underway in hundreds of organizations throughout the country, it all confirms both the possibility of progress and the great difficulty of such wholesale change. The payoff, however, can be considerable.

From the employee side, none is greater than the alignment of work with the vagaries of the human life cycle. Until quite recently, most work came in a one-size fits all mode. It was pretty much a full-time, 40-hour, 9-to-5, at-the-work-site proposition. You started "real work" after high school or college, put in 30 to 40 years, and retired at 65 or a few years before. Either you worked or you didn't—and frequently women didn't, laboring at home, but not in the paid workforce. Ill health or disability meant you were off work a little or a long while, or maybe permanently—or, depending on the disability, it meant you never got to work at all. If you wanted education or serious re-training, you did it at night, weekends or you had to pass it up. If you were a working woman who got pregnant, you got back to work as quickly as possible after childbirth. As an older worker, sometime in your 50s you settled on a retirement date, quit then and stayed retired. It was a pretty rigid set of patterns.

Not so today. We are all familiar with the demographic changes: almost two-thirds of women in the paid workforce, the raising of the retirement age, the intermingling of work with longer periods of education and re-training. Less familiar are the flexible work options that have evolved to accommodate some of these shifts.

The flexible options most relevant for our discussion are: regular part-time, job sharing V-Time (Voluntary Reduced Work Time), phased and partial retirement, leaves of absence, worksharing, flextime and flexplace/telecommuting. Each of these options can help solve a problem for a particular individual or group of people. But taken together, designed with the fairness of prorated benefits, given the imprimatur of the CEO and company policy, supported by solid program information and quality training of managers, and integrated into every unit, department and division of a company—this equiflex tool kit is more versatile, cost-effective and targeted than, and infinitely superior to, the blunt instruments of contingency. First and foremost, these options serve both employer and employee.

Brief definitions suggest some of the ways they can be useful to particular groups. Regular part-time allows less than full-time work with prorated benefits, for those who must or wish to work less than full-time. Job sharing is the splitting of a full-time position into two, with salary and benefits prorated; it allows the creation of part-time work in jobs which structurally need a fulltime occupant. V-Time is a temporary (usually 6 to 12 months) reduction to less than full-time, with a corresponding reduction in pay/benefits; this could be called "temporary part-time". Partial and Phased retirement programs allow older workers to reduce their hours for a period of time prior to retirement; phased defines a timeline to retirement, while partial typically sees a reduction in work hours with or without an early draw on retirement pay.

Leaves and sabbaticals can be paid or unpaid authorized periods of time away from work without loss of employment rights. Worksharing is a company-wide program in which all or part of an organization's workforce temporarily reduces hours and salary as an alternative to laying off some of the workers. Flextime permits employees to choose their starting and quitting time within limits sets by management. Flexplace/telecommuting is working at home or at a satellite facility on a regular basis.

Imagine these options applied to typical life cycles. Regular part-time works well for students and for older workers. Job sharing might be the choice of a professional returning to school or training opportunity or of an older professional looking to start up his or her own business. V-Time may be very helpful for a young mother with dependent care needs, or an older worker with a temporary disability or short-term spousal care demands. Partial or phased retirement might suit someone whose continued enthusiasm but declining stamina makes continued full-time work undesirable and early retirement equally so.

Younger workers might choose family leave, mid-life professionals may opt for educational leave or sabbatical, older workers could select a community service leave— and any one of them may need a medical leave at any point. Depending on the stage of life, worksharing may save anyone's job— and thus the dream of home ownership for the young, the college fund for the children of the middle-aged and the pensions of older workers. Flextime can allow for the constant juggling that faces anyone with dependent care responsibilities—be they childcare or elder-care—and can provide tremendous solace to older workers or others with light disability or health problems who may otherwise find the daily start time of the job a major source of stress.

Flexplace/telecommuting can be of great assistance to the new mother wanting to return gradually to work after childbirth, to those with chronic or temporary disabilities and to older workers desiring to reduce the frequency of their commute.

It is not hard to apply this range of choices to a typical person over his or her work life—or even to one's own. It is a useful exercise to do just that, and imagine that one had worked for one or a series of equiflex employers to date, rather than for employers not familiar with many of these possibilities. Projecting to the end of one's work life, the usefulness of these options for older workers becomes even clearer.

The real power of an equiflex strategy lies in the weaving together of the many unique work time patterns generated by each employee. Much of the ability to expand and contract workforces and/or labor time that has led to the contingent strategy can be better realized in the constant choreography of *internal* flexibility. And it can be done in the context of a regular workforce which enjoys fair treatment in matters of pay and benefits. The advantages in quality control, recruitment and retention and employee commitment are substantial—and sometimes measurable. We are confident that a comprehensive cost-benefit analysis of two comparable firms using these different strategies would give equiflex the edge.

If equiflex makes so much more sense, why, then, is contingency continuing to grow? And what can be done to reverse the course of events? The answers to both questions share the same root: employer attitude and peer group behavior. Contingency was described earlier as a two-tier workforce strategy, not unlike the two-tier wage systems that achieved notoriety with Frank Lorenzo at Continental Airlines and briefly swept the country. Long after some companies were noting the downside of these systems and quietly burying them, other companies were just launching them.

A similar pattern may well be underway with contingency. Companies we are in touch with who have been using these systems are having serious second thoughts, and considering quietly dropping them. The Equiflex Project is also engaged in a research effort to examine the claims and achievements of the contingent form of flexibility which we intend to publicize widely. As this sort of critical assessment takes place, especially among peers, the anticipated slowing down in the growth rate of the contingent workforce may intensify.

It may also be that the Conference Board study's conclusion that employers were planning to substitute more flexible scheduling—the options described above—for some of their flexible staffing options, could take place sooner than expected and with more intensity. There is a perspective that would explain such an outcome. One can view this issue of flexibility as the subject of a powerful, long-term negotiation among workplace forces. If the 1980s were the decade of employer-driven flexibility with its contingent face, we may now be entering the era of employee-driven flexible scheduling programs. An equiflex approach would allow the integration of employer and employee needs in a comprehensive system of flexibility.

Whatever the state of flexibility in companies today, it is clear that there is tremendous movement in this arena. The direction things take will seriously affect the working conditions, the family lives and the economic futures of millions of people, including older workers and the disabled. Regardless of how one assesses the contingency trajectory, there are two major areas for action on behalf of a flexibility that serves the productivity needs of the country and the life cycle needs of workers. The first we call private policy, and the second is public policy.

The contingent workforce emerged largely because of the private human resource policy decisions of thousands of employers. We think immediately of the Fortune 500 companies, which have indeed embraced this policy, by and large. Yet the largest single employer of direct hire temporary workers is the federal government—and under President Reagan, the upper service limit for a federal temp went from one year to four.

Employers want to offer these arrangements, and out of desire or desperation people take them. Our inclination in the Equiflex Project has been to try to persuade employers to adopt the concept of proration of benefits on the one hand, and to embrace the flexible scheduling options on the other. We have formed a corporate advisory committee and are engaged in research, publishing, speaking, consulting and training toward the end of flexibility under fair conditions.

We are organizing coalitions along these lines and encourage anyone with these concerns to raise a consistent banner for proration and integrated flexibility within their circles of influence. It cannot be stressed too much that contingency is an approach toward flexibility that exists on college campuses as hourly faculty, in research facilities as contract employees and in hospitals as hourly part-timers—it is happening within our domains and we can influence it there.

The public policy arena is an inhospitable one these days on these issues. But there is significant work to do. While some would argue that a legislative effort should be launched to mandate prorated benefits for part-timers and temps, we think the current climate makes such an approach a complete non-starter. The mandating approach also has some problems because of the inevitable exclusions of firms below a certain size, the tendency of the mandate to make health insurance even more tightly a condition of employment and the difficulty of crafting a policy that will guarantee coverage of all contingent workers.

We would focus instead on two general policy areas right now. The first would be the insistence that BLS be both ordered and funded to revise their data collection and reporting categories to more accurately reflect the nature of today's workforce, and to collect data on the conditions of employment and the social composition of those workers. Then we might know who is affected and how policy could improve their conditions.

Secondly, we would recognize that the nature of work and the workforce is changing dramatically and permanently; we are not going back to the era of "Leave it to Beaver." Flexibility is here to stay, and we must shape it. Clearly some of the policies constructed around the model of a full-time male breadwinner with a stay-at-home-wife are no longer viable. We need to re-think some basic structural issues.

First and foremost among these is health insurance. We have been talking about employers' desire to strip benefits and employees' tremendous need for them: the heart of this matter is health insurance. In conversation after conversation employers have told us that they wouldn't mind providing the other benefits— it's the health insurance with its rising and unpredictable costs that they are trying to get rid of. Employees similarly say they could live without the other benefits—it's the lack of health coverage that scares them.

It is time to take a long-overdue step and divorce health insurance coverage from the workplace. A national health insurance system would eliminate the most onerous aspect of the contingent workforce and would remove—or significantly reduce—the distortions created in the range of work schedule programs by this unfortunate social artifact.

There are additional steps that need to be taken, such as revising pension law to enhance pension portability, revisiting the minimum wage (again) and enforcing some reasonable upper service limit for workers called temporary. But there is nothing served by being exhaustive—or exhausting—in the listing. Suffice it to say, there is enough to keep us busy with these first few items.

Footnotes

[1]Belous, Richard, *The Contingent Economy*, Washington, DC: National Planning Association, 1989, p. 16.
[2]Ibid., p. 16.
[3]Ibid., p.17.
[4]Christensen, Kathleen, *Flexible Staffing and Scheduling in U.S. Corporations*, New York: The Conference Board, 1989, p. 3.
[5]Towers Perrin, *Workforce 2000; Competing in a Seller's Market— Is Corporate America Prepared?*, Washington, DC: Towers Perrin, 1990, p. 15.

Excerpts of Reviews and Comments

The needs for and advantages of greater flexibility in employment, and the inadequacies of contingency workforce approach are well stated in this paper. In the long run no one is well served when employees are viewed as objects to be used and disposed of as convenient. Taken together, the current extensive and increasing reliance on contingent workers, as generally practiced, and the substantial needs for flexibility in employment, present a compelling case for change.

One major difficulty with a contingent work force as it is generally practiced, is the detachment from benefits, especially health care benefits. This paper suggests it will be easier to establish a national health insurance program divorced from the workplace, than to achieve adequate coverage within a flexible employment system. The difficulties in achieving either are substantial.

The major implications of this article are for public policy and employer practices. The recommendations generally seem justified and should be supported. However, I suggest consideration of the following points.

With respect to health benefits, I believe simultaneous effort is needed towards both proportionate benefits within flexible employment and/or more adequate and comprehensive national health care system, independent of employment. This presents a choice of alternatives either of which is better than our present status of inadequate employee benefits and the kind of publicly supported socially inadequate and privately expensive health care system we now have.

With respect to helping handicapped and older persons gain access to employment, it seems desirable to support policies which increase employer benefits (low costs to employer) that are associated with flexible employment patterns. The more beneficial flexible employment is made to employers, the more job opportunities will likely be made to older persons whose interests and needs can be met by such flexible work patterns. With respect to making employment attractive to older handicapped persons, however, those same policies which lower employer costs may be seen as disincentives to the potential employees. Employers might attract more older workers at the same cost to themselves, by being highly flexible in the form remuneration is given. Cash is more important to some, other benefits are a priority for others. Flexibility is needed both for employment patterns and the form which remuneration can take.

—Richard Blake

This paper gives a current perspective of the changing face of the work force. The EquiFlex System of time management creates for the disabled work force options since it is an employee driven flex scheduling system. The older disabled worker is at high risk of being part of the contingency structure and may be easily satisfied since it is some kind of work. For many older visually impaired persons the opportunity to work and be productive is more highly valued than income and related benefits— a moral dilemma.

This type of work flexibility would allow time for rehabilitation to take place and allow for return to the work place. However, the older disabled worker is at high risk of being part of the continuing structure and may be satisfied with his because it is some kind of work.

This article brought many questions to mind:

- How does the disabled worker fit into this model?
- Do older people with low vision want to work:
- How will the Equiflex system affect the disabled person's benefits?
- How does rehabilitation fit into the Equiflex model?
- What is the definition of a light disability? Is low vision a light disability as defined by the author?
- Is the federal government ready to become a role model for the business community by instituting flexplace and telecommuting?

There is a need for further research to determine the efficacy of the proposed model for older workers and older workers with disabilities. Rupert alluded to the need for research with his suggestion for the Bureau of Labor Statistics to collect hard data on the demographics of the contingent worker. This data would provide answers to questions such as:

How many older people with disabilities are contingent workers? Where do they live? What kind of jobs do they have? What are their average earnings? What is their level of job satisfaction?

—Susan Jay Spungin

This is a thought-provoking paper. The "Equiflex" strategy offers benefits not only for older workers, but for all persons desiring a non-traditional work arrangement. It offers potential advantages for employers as well, since it supports the retention of talent within the organization over the lifetime of its employees.

The author suggests that equiflex "would be a profound change for employers to make." It can be argued, on the other hand, that employers are already confronted with a variety of pressures which build the need for flexibility into their organizations, such as state requirements for granting family and medical leaves, state and federal job accommodation requirements for workers with disabilities, and the federal Worker Adjustment Retraining and Notification Act, to name a few. The fact that contingent workers may not receive health insurance benefits should not be attributed to any evil intent or motive of the private sector. Temporary employment agencies existed long before the widespread use of core-ring strategies come into being. Employers have simply utilized the existence of contingent workers to respond to increasing legal requirements and competitive business pressures.

The real issue is not whether employers want flexibility in their workforce, because they do. Many employers have, in fact, adopted their own, voluntary approaches to flexibility in the workforce, of which a "contingent workforce" or "core-ring" strategy is only one.

Rather, the question is whether there is a public policy flaw in a system which allows people to work in contingent arrangements which may not provide them with all of the benefits of an otherwise regular employee.

—Linda I. Workman

Unless our culture begins to think through our treatment of people who are aging, we will not only be putting them on the shelf at a very early age but that shelf will be at the very bottom of the showcase.

Perhaps no one has been more affected by the onset of the hourly, part-time, no-perks job than has the older person— very often female, unskilled and disabled. Whole industries have been built with no employees except supervisory staff who are full-time workers with a decent fringe package. Industries have also grown which supply these workers to the employers and take part of the salary in the bargain.

Our national health insurance policies are really most notable by their absence. We still tie health insurance to work. The sooner these two major aspects of life are separated, the better, so that one will neither have to seek or refuse a job simply because it offers or does not offer health insurance nor will others be trapped in a job only because of the fear of loss of the health insurance which it offers.

It is not safe to assume that older people do not need health insurance nor that a job for them is just to mark time. Both can be genuinely crucial aspects of some older people's lives well into their 70s.

Legislation needs to address what has become a national health insurance crisis. The amount of older people who cannot afford Medicare supplementary insurance, or fill their other health care needs, continues to grow.

—Richard P. Oestreich

The author provides an excellent summary of issues faced by "contingent workers" versus those who function under the concept of equitable flexibility. The author accurately points out the difficulties of crafting a public policy that will guarantee coverage for all contingent workers. He also stresses the desire of workers to maintain health insurance coverage while maintaining some degree of flexibility in work schedules. Certainly this will have an impact on the health care industry as it relates to providing full fringe benefits for part-time, temporary and/or independently-contracted workers. This could also have some implications for the Title VI- Part C Supported Employment program under the Rehabilitation Act, as amended,(i.e., current regulatory guidelines require an average employment of 20 hours per week for supported employment cases). The author makes reference to some research that is underway with regard to issues surrounding work sharing as well as flex time/equal flex for part-time employees. He also mentions flex place/telecommuting for those who work at home or at a satellite facility. There is certainly a need for additional applied research in this area to provide empirical evidence of how this could impact upon employee fringe benefits, particularly as it relates to mandating prorated benefits for part-time workers and/or temporary workers. The comprehensive system of flexibility proposed by the author would certainly impact upon private policy as well as public policy as it relates to employee benefits.

—J. Elton Moore

Paul Rupert's paper was a well reasoned analysis of current business approaches to the tightening economy and prediction of future business responses and labor market dynamics.

The presentation of the core-ring approach accurately reflects my observations in several private businesses and at some points in the federal government. His description of the dramatic increase in temporary employees and other "contingent workers" and caution over future similar increases are well thought out. I believe that Mr. Rupert's paper would be more valuable with the factoring of the Americans with Disabilities Act. I have a concern that this may double the negative effect of increasing health benefit costs and private industry may move to continue its movement toward a short-sighted contingent workforce approach out of unreasoned fear of the combination of increasing health care costs and an increase in the percentage of workers with disabilities in the workforce. When influenced by an increase in the age of the workforce, business may not move in the positive future direction of the equitable flexibility described in this paper. I fear that there will be mass layoffs and hire-backs of the same individuals as private independent contractors. It seems obvious to me that those businesses that do move towards the equitable flexible approach will have a competitive advantage in the medium and long runs by having a stable, flexible and cost effective workforce. Business by maintaining maximum benefit flexibility will be able to meet its needs, its employee needs and its customer's needs, while meeting its community responsibility.

I do not foresee the total implementation of the equitable flexibility approach in the federal government. The concept of flexible hours of work is already in effect. However, the idea of other than total uniformity with health, life, long-term disability, and retirement benefits would not be accepted by the unions, in my opinion.

I thought that this was a valuable paper that brought a major concern to light. *(The opinions expressed are those of the author and not official RSA positions.)*

—John Nelson

Chapter Five

Empire Strikes Back: Meeting the Health Care Needs of an Aging Workforce

Steven W. Leclair

A common theme heard among many employers is that they do not know how to address problems they feel are associated with an aging work force. They often find a lack of health care and rehabilitation alternatives, injury management services, and case coordination approaches designed to protect the employability of the older worker. There is rarely an attempt to offer preventive programs prior to the onset of an impairment or disability, and there is little or no attempt to promote a systematic return to work effort. This is especially true if the worker is believed to have reached maximum medical improvement and could possibly qualify for other types of support such as early retirement, disability compensation or social security. The older worker is therefore "permitted" to withdraw from the work force with little or no attempt from the employer or health care provider to find alternative solutions.

While the alternative to leave the workforce has been chosen in many employment settings (either actively or passively), demographic trends and productivity analyses point to the fact that not only is this a waste of human potential, but employers may no longer have the "luxury" to approach the problem in this manner. According to the Hudson Institute's report entitled *Workforce 2000: Work and Workers for the 21st Century* (Johnston and Packer, 1987), several major demographic issues will influence the workforce as we approach the 21st century:

- The work force will experience its slowest growth since the 1930s;
- The average age of the workforce will rise (due to both a growing older population as well as a smaller population entering the workforce);
- Women will represent a greater percentage of the workforce;
- Minorities will increase their share of persons entering the workforce; and
- Immigrants will represent the largest share of the increases in the workforce since the First World War.

STEVEN W. LECLAIR is Vice President for Clinical Services, National Industrial Rehabilitation Corporation, Worthington, Ohio.

All of these trends, coupled with general workplace trends such as a greater focus on quality control in order to be more competitive in global markets, an aging industrial infrastructure, heightened reliance on skilled workers, and an ever-increasing use of sophisticated technological approaches for performing all aspects of work, lead us to the conclusion that future employers will be even more in need of productive, capable workers who have the capacity to be both participants as well as guiding mentors in the work world of tomorrow. The aging of facilities, equipment and delivery mechanisms noted above is a problem that can have a devastating effect upon a company's ability to compete in today's marketplace. However, an aging work force has a trait that material resources lack...the ability to adapt, to learn new skills, and to capitalize on past experiences as learning tools for the needs of tomorrow's work.

Sandell (1985) reported that approximately 19% of the total U.S. population was between the ages of 45 and 65. It is estimated that in just the fifteen years from that point to turn of the century, this percentage will have risen to 23%. While this appears to be a small rise in percentage, this actually translates into an increase of more than 18 million people.

We know that as people age, they become more at risk for physical impairment and work disruption. Mitchell (1987) identified that while older workers (45+ years of age) have less risk for injury, they often experience greater periods of work disruption when they are injured in comparison to younger workers with parallel experiences. Yelin, Nevitt, and Epstein (1980) noted that older workers require more time to recuperate from illness and injury. In a very interesting study outcome that reinforces the crucial role that the employer and the employment setting plays in the return to work process, Liang, Larson, Thompson, Eaton, McNamara, Katz, and Taylor (1984) found that impairment alone (among a population of workers with rheumatoid arthritis) was not predictive of work disruption. Instead, they found that job flexibility and work satisfaction were predictive of successful continuation of work among older workers. When we study the needs of an aging workforce, it will be important to first take a serious look at the type, scope and quality of health care services that are available and used. Based upon the work of Liang et al., it will also be important to look at how

the policies, procedures and atmosphere generated at the work site may influence the ability to retain one's employability following an illness or injury.

The employer must become an active participant in the protection of the older worker's productivity. Through effective prevention efforts, the delivery of focused injury and illness management services, and the development of fair, safe, and consistent work retention and work return programs, the employer can ensure that the most important resource of the company, its human resource, will be protected, available, and prepared to contribute to the company's productivity.

In order to explore this topic in as realistic and functional a light as possible, it will be presented in "story" form, a story about a company and the experiences it had in approaching issues associated with an aging work force. The story is a fictionalized account made up of a composite of companies with whom our organization is familiar and has worked. The following story not only portrays the journey of this company, it presents a view of an active model for preparing and linking with health care providers in the community. While the account is fictional so that the privacy of individual companies can be ensured, all of the problems, actions and outcomes have been experienced by real people in real companies over the last five years.

As the story of the company evolves, the reader should attend to the following areas of concern:

- Problems experienced by the company that are related to an aging workforce;
- Problems experienced by the company that are *perceived to be* related to an aging workforce, but may have other causes;
- The different levels of proposed and attempted solutions through which the company moves and why they resulted in such variable outcomes;
- The consistent reactions of the health care and insurance systems;
- The methods used by the company to become an active participant in the process of illness, injury, and disability prevention and management; and
- The importance of clarity, consistency, honesty, and individualization to the success of the company in addressing the identified problems.

"Empire Glassworks, Inc."

Empire Glassworks is a single-site industrial company with 1,200 employees (1,000 hourly and 200 managerial, clerical and sales) located in a medium-sized Midwestern city. Empire is in the business of manufacturing and delivering a variety of glass and plexiglas products used as protective shields and surfaces, containers, and raw material to be used in secondary manufacturing operations. The company has been in business for 80 years, starting as a standard glass works and evolving over the years to its present format (in response to technological advances and shifts in market demand). This was a family owned business until the mid-1970s, when a diversified manufacturing corporation purchased the company.

Empire Glassworks has experienced several downsizings in the last decade. A combination of layoffs based on seniority and the elimination of vacant positions were used in each of these downsizings to reach the number of workers that the organization could support. The process was straightforward and consistent so even though there was considerable anxiety and unhappiness involved, the anger was minimized. In 1980, the company had more than 2,500 workers at the single site. Due to increased competition and changes occurring in the demand for the product, the company steadily reduced its size to its current work force. Interestingly, a strengthened focus on quality control and the incorporation of new technology into the manufacturing process has allowed the company to maintain 1980 production rates, despite the reduction in staff. No "fat" exists in the system at all....it is now streamlined to the point where even small gaps in personnel or individual productivity can affect the company's overall profitability.

The work force is organized, with two unions representing the hourly employees (one covering the manufacturing group and the other representing the trucking and product delivery system). The infrequent hiring that has occurred in the last decade has tapped union members who had been laid off. Due to these factors, the average age of the workers is 51 and the minimum age for a current hourly employee is 37. The job at Empire is seen by many as the best job in the community, both in terms of pay, work tasks, and atmosphere. The community believes that the "worst" appears to be over and existing jobs are secure.

There is much ethnic diversity in the plant. Approximately 35% of the employees are foreign-born, representing Hispanic cultures from Central America and Puerto Rico, Eastern Europeans from Poland and Hungary, and a large group of people originally from Greece. This diversity weaves an interesting fabric of culturally influenced attitudes, expectations and behaviors related to health care service delivery, employment, and worker self-concept regarding aging.

Both the work environment and the jobs themselves are quite safe. The number of worksite injuries is below the expectation for their industrial classification. While the buildings and much of the equipment used in both the manufacturing and shipping operation are quite old, the management has worked diligently to meet or exceed accepted safety requirements. The plant operates a 2-shift, 6-day work week, with most hourly employees averaging between 48 and 60 hours per week. Management has identified that this has created an optimum schedule to balance personnel needs, productivity, and profitability.

Over the past few years, the company has identified problem areas that have influenced their ability to be competitive in their markets. They have noticed a lessening in productivity among many individual workers. Supervisors have often chalked this up to "laziness" or being "bad workers" (referred to as malingerers) and have tried to intervene (unsuccessfully) with disciplinary measures, but human resources management has begun to see a trend among this group as being high users of the health care system and being more apt to experience work site injuries and filing a worker's compensation claim. A general increase in worker's compensation costs has confused and worried the human resources management. (This is especially true because in this state, the worker's compensation benefits extend beyond retirement age and continue until the death of the claimant.) The rise in cost is not related to a greater number of accidents per se, but to an increase in claims related to overuse and repetitive motion disorders, resulting in joint, tendon, and muscle pain. To complicate the increase in the number of claims, the company

has recognized that the average number of lost work days per claim has grown dramatically as well. An increase in people choosing early retirement options has also occurred. Finally, an increase in grievances from the unions has also been noticed. This is notable, because except for a few isolated incidents the relationship with organized labor has always been positive in the company. Many of the filings appeared to be in reaction to an inconsistent return to work process (following work disruptions caused by work related injuries as well as off-duty injuries and illnesses), creating much anger and confusion among the workforce.

Initially, Empire management wasn't sure if these problems were indicative of indistinct or unfocused labor relations problems, safety problems that are going unrecognized, a "sign of the times" with increases in similar difficulties seen in many other organizations who had an older work force, or even a delayed reaction to the sale of the company and changes that occurred as a result of becoming part of a much larger organization. In short, they had many "leads" but were somewhat overwhelmed by the complexity of the situation.

For propriety's sake, they contacted the corporate headquarters to see if they could learn from the experiences of other divisions who may have experienced similar problems or concerns. The mother company was not aware of any other concerns in this area, but did point out that Empire Glassworks was one of the few divisions left in the organization that represented an older work force. Of the 4 other divisions that had similar work forces, the corporation had recently sold one and shut down another in order to cut their current or potential losses. Corporate headquarters indicated that they would be "studying this problem." This made the Empire management nervous, questioning whether they made the right decision even mentioning the problems to corporate. Their cost efficiency as a division had been on the wane and they felt it was possible that they may be next on the corporate chopping block if the situation didn't improve.

Empire management decided to take the initiative and become aggressively proactive in their approach to the current trends. Since many of the problems appeared to be associated with injury, illness, disability and in the company's interaction with health care community, they decided to discuss the situation with local providers and seek assistance in defining and addressing the problems.

The company had developed a positive relationship with one of the local hospitals, relying on their ambulatory care services for any pre-employment or DOT physicals that were required and the emergency service for any work site accidents. The hospital was pleased and obviously quite excited about the opportunity to work closely with the company. This gave the hospital the opportunity to present information about a developing occupational medicine and industrial rehabilitation program. During an initial meeting where the company presented their concerns and sought the hospital's advice on how they may attend to the problems, the Human Resources Manager got the feeling that the hospital's "individualized menu approach" which was said to be designed to meet a variety of company needs was, in actuality, just a list of intact and existing services that reflected what the hospital thought area employers would need. The only flexibility in the system was the company's ability to choose among the predetermined list. No potential (or willingness) to individualize the services was seen. While hospital personnel talked as though they wanted to listen to the concerns of the company and help them address their problems, the actions they took did not indicate that they possessed the expertise or the business experience to help identify the underlying causes of the problems or develop reasonable and effective responses. The attitudes on the part of health care providers appeared to be negative toward the older worker's potential for retaining employability following a work disrupting injury or illness. The interaction with the hospital (and other health care providers in the community) was disappointing.

The benefits coordinator noted that both the worker's compensation and sickness and accident insurance carriers had often indicated that they would be available to consult with the company in order to facilitate cost savings related to health care. Even though the company personnel weren't convinced that "cost savings" was the real issue (not as much as intervening with the work force and ensuring that effective health care was available to meet their needs) they were willing to give this option a try. At least they would talk with representatives from the companies and see what they each could offer.

The insurance carriers reviewed the experience of the company in their respective areas prior to the meetings. Both insurers agreed with the company's tentative conclusion that, for whatever reason, the outcome of the health care services being received was not as positive as one may expect and that, in some instances, the system may actually be promoting extended work disruption. Both insurers indicated that the best way to address these issues was to take advantage of the utilization review/case management program that each had recently implemented in their organizations. Again, the consultation and assistance that the company sought resulted in a sales pitch for an "exciting new product line," seemingly designed to address all of the company's woes but, in reality, it simply was a result of portraying the company's problems in such a way that their new program could be offered as the solution.

Being seasoned veterans in the world of sales, company personnel were able to identify that a "sale was on" in each of the above attempts at seeking assistance. They also became aware of the fact that their needs weren't really being met by either of the two concerns (providers or insurers), and the suggestions of cost savings had some pretty hefty price tags associated with them.

They decided to put the offers on hold and to study their situation themselves, attempting to identify the underlying issues and the actions that would be necessary to address them.

Since much of the difficulty had been recognized by the union through investigations related to the grievances, the management team decided to ask the union to join with them and form a study group to identify and define the issues related to their current situation. The group was made up of one representative from the human resources department, the safety director, two front line supervisors, and two representatives from each of the two unions. The group would leave membership open for additional people if and when the need would arise. A charge was given to the group to identify what the current problems are, what problems could be anticipated in the future, what the needs are, and how to address those needs.

In order to gain initial levels of information and to identify the problem areas, the group reviewed existing reports from insurance carriers, interviewed workers and supervisors, and identified what other organizations in the field have done. The problems that were identified are the following:

- *Increased use of the health care system*: A slow but steady increase in the use of health care services has been experienced over the past five years. This has resulted in a sharp rise in premiums (a function of system-wide premium trends, the company's increased usage, and increased associated with greater loss risk of older insurees).
- *Increased worker's compensation costs*: An increase in the number of claims (both medical only as well as lost time claims) coupled with a 40% rise in the number of lost days per claim have resulted in a marked jump in worker's compensation premiums and reserves.
- *Inconsistent and unrealistic work return procedures*: The work return process for persons experiencing a work disruption due to either a work related injury or a non-work related injury or illness was seen as managed inconsistently, poorly planned, and often unrealistic in its operation. The result was employee unrest, supervisor frustration, and increased costs related to work disruption, decreased productivity, and the effects of "sabotage" (both on the part of management and labor) in those instances where self-interests were conflicting or in competition.
- *A general lack of awareness and knowledge of the needs, capabilities, and vulnerabilities of an older work force*: It was concluded that all of the relevant parties (management, labor, health care providers, and insurance representatives) had contributed to the problems existing in the company by their lack of knowledge and misperceptions regarding what was necessary to help promote and retain the employability of an older work force. Prognoses were made without a firm grasp of what a worker's capacities really were, treatment focusing on symptom management was offered rather than focusing on an active retention of capability and productivity, and an overall view of fatalism was often experienced ("he's old and getting close to retirement anyway" or "she won't be able to recuperate from this illness enough to return to work... an older person just doesn't bounce back the way a younger one can.")
- *Limited access to health care programs that would meet the needs of an older work force*: The work force typically was seeking treatment from family physicians who, despite all best intentions, were not well versed in the work return implications of many temporary or permanent impairments related to injuries or illnesses. In many instances for this company, these physicians were chosen because they were able to speak the worker's first language. Their view was typically one of treatment and symptom management— not the functional implications or the enhancement of one's capabilities despite the existence of the impairment.
- *Minimal or inadequate communication lines were developed between the employer, the worker, the health care provider and the insurer*: Too many workers were left to their own designs in the health care community, often to be found floundering in a system which isn't necessarily designed to address issues which are most important to them (i.e., How is this going to affect my ability to do my job? When will I be able to return to work? What needs to be changed with my job or the worksite to help me return as soon as possible? How will this affect my income?)

The next step was to identify the work force and company needs associated with the above problem areas. The study group identified three components they felt would be needed to respond to the above problem areas:

- The availability of strategic linkages with health care providers and hospitals who specialize in working with disorders relevant to the older worker and, more specifically, with disorders which have been shown to be relevant to the work force in this company.
- An educational awareness process promoting the development of knowledge, skills and facilitative attitudes among management, labor, health care providers, and the insurance carrier regarding the reality of aging, the retention of functional capability, and measuring a person's capacity to work.
- A method of assisting the work force to access the system of services that is developed. This method should include an identification of an invitation to people who could benefit from the system of services.

Management understood that in order to give this study group a viable charge, it was important for them to be aware of the level of resources that were available for any program development efforts. This was a very difficult step, politically and practically. The perceived risk was that if the work force and community knew how tight the budget actually was and how close to the line the company was operating, this could result in large scale disillusionment and anxiety, potentially leading to an increase in worker's compensation claims, work disruption, and requests for early retirement (illustrations of a work force seeking a stable "out" in light of a company's uncertain future.) These, and other reactions on the part of the work force, could contribute to decreased productivity thereby placing the company in even more of a vulnerable position in the eyes of corporate management.

Regardless of the risks associated with the above, management decided that the importance of realism in the development of a plan to address the problems outweighed the risks associated with an honest accounting of the situation. A little information would appear suspect, so management decided to lay out the situation to the study group, presenting the financial position of the company, its vulnerabilities within the larger corporation, and a realistic projection of what resources were available to address the identified needs. The company management stepped back to see what would happen when this information "hit the streets." They didn't have to wait long. As expected, the representatives from each of the two unions reported back to their respective constituencies all that had transpired in the study group. A short period elapsed as the groups digested the information. After much anxiety and guarded anticipation on the part of management, an interesting thing occurred. The unions issued a joint statement to their membership, voicing support of the study group's mission and going on record as "willing and capable partners" in the company's efforts to attend to the needs of the work force and to ensure that individual worker's (and, therefore, the company's) productivity was maintained and enhanced. They went on to recognize the changes in competition,

markets, and business trends that have occurred over the last decade and insisted that the union must be aware of these changes in order to intervene appropriately on behalf of the labor force. The statement also noted that while the company was operating within a tight margin of profit, it was a viable, competitive entity in its market and would continue to be so as long as the work force remained vigilant, prepared, and active participants in the process.

This statement astonished company management. Not only did it reflect a level of foresightedness that the company had not anticipated, it portrayed a clear understanding of the company's position and where it needed to go in the future. What also was notable in the statement was the fact that it was rare for the two unions to discuss anything and they had certainly never issued a joint statement before, preferring to address the needs of their memberships independently (although some collaboration had occurred in preparing for the negotiation of union contracts.)

This response was seen by management as the "green light" to take the study group to the next level of its charge. Both management and labor felt that the study group had functioned well and had achieved much in the short time they had been together. Therefore, it was decided to retain the same membership and shift the group's focus from that of studying the problem to one that would lead the organization in the development and implementation of a plan. Selected members were given the task of researching ideas from employers outside the corporate structure who were experiencing similar circumstances so that they could minimize their own work, taking advantage of someone else's successes (or failures).

First, the group developed a plan of action based on the needs identified earlier. This plan of action reflected most of the needs but was developed within the tight parameters of budgetary and personnel limitations. The essential components of the plan included the following:

Rationale/Intent of the Program

- This plan should ensure high quality treatment in order to promote the retention of productivity and employability;
- Internal and external programming should be available to ensure effective, safe, and timely work return following an injury or illness; and
- Education and training of workers, management, health care providers, and insurance carriers to understand the realities of the older worker, the issues in operation in this company, and the proposed program to address these issues.

External Components of the Program

- Linkage with health care providers who specialize in disorders relevant to the work force;
- Linkage with health education and management systems who would be available to address the primary prevention needs that would be appropriate for the organization; and
- Linkage with a comprehensive medical rehabilitation program (complete with a work hardening service) which is willing and able to address the rehabilitation and return to work needs of the older worker. This organization should be capable of performing on site job analyses to establish the physical demands of the job, identify what and where job accommodations would be appropriate and be willing to work closely with management and labor to promote work retention and return to work efforts. The evaluative arm of this organization should also be available to perform regular functional capacity evaluations with workers who have been identified as vulnerable for increased performance problems due to degenerative disorders and to arrange for appropriate care or services for those whose capacities are found to be inadequate to meet job demands.

An Internal Management System

- An organized system designed to follow the worker to promote effective communication between and among the providers, management, the union and the worker and his/her family.

Trigger Points and Outreach Efforts

- Identify methods to help people access the system of services and care including both a self-referral mechanism and the use of an automatic trigger point using a negative performance appraisal that is potentially related to a physical disorder or lessening of physical capacity.

Methods of Approaching Different Segments

- Design a method of introducing the program to different segments of the community who will either be affected by or relate to the plan. Specifically, design a system to approach and inform the following groups about the plan: a) local health care providers; b) corporate leadership; c) insurance carriers; and d) supervisors and labor.

The cost of the plan would be minimized by the lack of an additional intact service; the reliance upon existing fee for service arrangements covered by the insurance carriers (sickness/accident and worker's compensation, respectively); and the linkage with providers who understood the issues, consistently offered high quality services, and would communicate openly and in a timely fashion with the workers and program heads. The worker would retain the right to seek care from a physician or provider of their choice (this is built into the health care insurance plan and is a state regulation for the worker's compensation coverage.) It will be the role of the program to endorse specific types of providers and to develop a sense of trust among the work force that the providers, programs and services included in the program were chosen based upon their quality, their objectivity and their potential to help the worker get better (not just as a cost savings for the employer.) They felt it would be important, however, to be honest in their acknowledgement that cost savings was one of the essential goals for the program. For those workers who did prefer to seek care from their personal physician (this was especially common among the foreign-born members of the work force), an active communication program would promote a positive link between the provider, the worker, management and the union. This is designed to combat an unfortunate result of an unorganized system. Despite best efforts on the part of management, the provider and others, people who are off work due to health related concerns or are working but simultaneously receiving care for an ongoing problem often find themselves "lost" in the abyss of the health care community, unsure of what to do and often losing contact with the work site more

and more each day. This process is especially true in the case of an older worker, where attitudes on the part of the health care community may be based on an unrealistic view of that person's ability to sustain necessary levels of physical activity and therefore to retain one's employability.

The members of the development group approached company management with the draft plan. Through the membership of management representatives, the company had been aware of the progress and most of the specific areas of focus throughout the process (as had the union leadership.) The development group decided to be very aggressive in their approach to the providers and insurers (while ensuring that the program itself would not be perceived as negatively aggressive internally.) They decided to present the plan and negotiate with the community in exactly the way that they would negotiate in a business interaction. They knew what they needed and they understood the limits of the resources that were available to invest in the program, but they also were aware that the cost of not following through with the program would be a slow, but steady decline in the ability of their company to compete in the marketplace. They believed that this decline would be caused either by an actual degeneration in productivity caused by increased incapacity or, more likely, by the perceptions and attitudes toward the older worker held by others outside of the company such as:

- Physicians limiting the functioning of workers due to their own lack of understanding of methods to assist in the retention of functional capacity to meet the physical demands of jobs;
- Supervisors and human resource managers who lack an understanding of job modification or worksite accommodation to promote job retention and/or job return; and
- Insurance carriers who focus on identified levels of "risk" that are based on actuarial tables reflecting a long history of the attitudes and behaviors of those mentioned above, limiting the older worker's ability to retain employability or to receive appropriate care by providers who have a functional understanding of the relationships among illness, treatment, and work for this population.

In their dealings with the community providers, the company's catch phrase quickly became "why not?" When providers and insurers replied that what the company wanted was unrealistic or they were not prepared to respond to these areas, the firm response of "why not?" questioned them in a way that was unique in their experience. The company took control...knew what it needed, knew what it wanted and sought these things in the community. The link between management and the union formed an alliance that allowed them to negotiate from a position of strength and facilitated a level of mutual understanding that was very powerful. The company's efforts forced the 3 local hospitals to collaborate and approach them with an organized plan to meet their needs, each one providing a component of the service that reflected its own strengths and interests.

The company sought training resources from a local college and worked with them in a similar manner. Realizing that they needed a pivot person to keep this effort organized and moving throughout the crucial development period, they decided to provide an internship experience for an advanced graduate student in public health and had that person work to arrange the program, keep it organized, develop a data set for evaluation purposes, and arrange for the education seminars. The collaboration between the union and management had been so effective in the development phase that it was decided to implement the program with joint management/labor leadership. Each entity had its own responsibilities with common interests in monitoring and evaluating the performance of the overall program.

The program proved to be extremely successful. A 6-month start-up period was dedicated to the development of the project (coinciding with the internship.) The end of the first year saw a 60% reduction in lost work days related to both work related and non-work related injuries and illnesses; an 80% reduction in use of early retirement, a 12% increase in overall productivity; and significant increases in the individual productivity of those workers who had actually participated in the program. Attitudes on the part of supervisors, management, and labor were very positive about the program, feeling as though it was worth the effort. Aside from the initial development costs related to the lost time of the study/development group and the cost of the intern, the program was projected to incur less of a cost for the insurance programs than in the previous year and it was projected that the cost for year #2 would be even lower, given the fact that the program would be operating more smoothly after the first year's "kinks" were massaged out.

The Inside View of Empire Glassworks: Summary and Conclusions

Well, that's the story of Empire Glassworks. True, it's a success story and sometimes we don't see (or expect) the level of success achieved by this company. What made this experience different? What can we learn from the story? What were some of the most influential factors involved in their approach?

The problem had evolved over a period of time. It had seemingly "crept up" on the company management. There were some initial examples of questionable reactions to the problems (i.e., supervisors voicing opinions about "lazy" or "bad" workers and the union filing multiple grievances regarding inconsistent and ineffective work return experiences.) However, the vigilance of the human resources department assisted in identifying trends that were occurring in the work force, its use of health care services and systems, the incidence of lengthy worker's compensation claims, etc. This awareness helped move the company past the most common series of reactions to such problems, the knee-jerk attitudes and behaviors which are mired in blame, myth, and an uninformed fatalistic view of the older worker. These attitudes invariably lead to frustration, anger and inappropriate intervention strategies that grow in a spiraling fashion until the true state of affairs becomes invisible and inaccessible.

Rather than succumb to the popular view, the company decided to study the problem to identify a reasonable course of action. Their first line of inquiry took them down the traditional route of seeking assistance from perceived experts in the field... health care providers and insurance carriers. This seemed to be a reasonable course of action, especially since each of these entities had identified themselves as a resource to help the company to address this type of problem. The company quickly suspected that these "resources" may actually be a part of the problem themselves. It appeared that their proposed solutions

had neither the creativity nor the specificity required to address the problems.

At this point, the company made a shift in its thinking away from what the "system" typically demands to a more unique view. They decided that the only way to identify what was truly happening in the company would be to review it very closely themselves. The company knew that with an average age among hourly employees of 51 and a very demanding corporate headquarters reviewing their experience, they didn't have the opportunity to sit back and "wait out" the problem or resort to "tough" tactics, attributing blame on the employees who had become the focus of their attention. They understood that their actions had to be decisive, well thought-out, and (most of all) successful. Management also believed that union involvement at this level would offer them information that would otherwise be unavailable to them and any proposed solutions would be endorsed more readily if the union was directly involved from the beginning. Therefore, management and labor joined forces to identify what the problems and associated needs were in the organization, with a charge to identify the "truth", regardless of its political sensitivity or practical complexity. This was a unique opportunity for the company to "take control" of their own destiny.

The company challenged both the "system" and itself. In being open to hearing the "truth" (especially about its internal reaction to the existing problems and how these actions may have contributed to the development and maintenance of the problems themselves), the company was able to establish a base of honesty and objectivity which would increase the potential for success in any intervention alternatives developed.

The company found, in most instances, the quality of the mechanics of the health care system wasn't the issue as much as the attitudes of providers and insurers which limited the functional generalization of treatment regimens. The attitudes and behaviors of company supervisory staff were also identified as problematic. The lack of knowledge and inability to respond to the needs of the workers limited the company's efforts to return people to work in a timely and safe fashion following a work disruption or to assist workers in retaining their employability in light of a long term illness or chronic impairment.

In the development and implementation of the intervention plan, the company did what it had always done best, approaching the process in a competent, businesslike fashion (the very way it had been able to survive throughout the last decade.) The key was that it expected from the health care community and insurance system a level of service and responsiveness that it would expect from any of its "suppliers." This was a very different position, especially for the local providers, one which challenged them to direct their own resources in a direction in which they were not really prepared to move. The company wasn't being unfair with the providers, they were simply establishing some control over the relationship, requiring a level of accountability that would be deemed reasonable in any business interaction. The need for this approach was established by the level of resources that the company had available to invest in the effort, requiring them to keep a very close lead on the expenses but still ensuring that the necessary services were available and accessible to the work force. The recognition that forging strong linkages between the company and a blended group of health care providers chosen to meet the particular program and geographic needs of the workers was an important component of the program. The company used a list of informal evaluation criteria in approaching different health care providers. This was not used as an exhaustive or exclusive list but, rather, as a method of gaining information about the providers in areas that were of particular interest to the company. The following is a short description of the list:

- The provider should demonstrate knowledge of the company, the types of illnesses or injuries most prevalent in the work force, relevant health care and worker's compensation regulations, and the cultural context of the community.
- It should be reasonable to assume that the worker will receive the best possible care from this individual or program.
- The service should be able to demonstrate consistency over time, from one worker to the next, or from one provider to the next, in a group practice. An important area they looked at was whether the company had a history of doing what they said they would do (follow-through).
- The program should be accessible to the work force both physically and in terms of its hours of operation.
- This program is capable of providing high quality care, given the number of people being served.
- It will be reasonable to assume that this program will maintain acceptable lines of communicating with the company (as appropriate), including the generation and forwarding of relevant reports in a timely fashion.
- There is evidence to conclude that this program views the older worker in a realistic manner and will develop effective recommendations that are based on an understanding of the job, the worker, and generally accepted employment and treatment practices.
- This program is willing to collaborate as a team member and at least share any decision making responsibilities in those areas where collaboration with the company, labor and the worker would be important.

An important investment that the company made was to initiate a training effort to ensure that not only management and labor were aware of the myths and realities associated with older workers and their retention of productivity and employability, but that the local health care providers and insurance carriers possessed the same level of understanding. This effort was not intended to promote or reinforce a "company view" of the older worker but, rather, to ensure that the level of knowledge and awareness was raised to a point where medical/functional prognoses, disability determinations, and return to work plans were based on a realistic appraisal of the data and not influenced inappropriately by attitudes based on misinformation.

An important aspect of the project implementation was the system designed to manage the ongoing program. A joint responsibility involving union and management was initiated to maintain the positive relationship that had been developed during the earlier phases. This collaboration also promoted ongoing communication within the organization which helped to ensure that any communication with outside providers and insurance carriers was productive and received by all relevant parties. A regular reporting mechanism was used to monitor the effects of the program as well as its day-to-day operation. This group also served as an internal consulting and arbitration arm for complex

or difficult cases involving unique work return or work retention issues.

It is obvious that Empire was able to cut through much of the mystery that is sometimes involved in problems associated with an older work force and focused on the context of the issues. They identified what was reinforcing and supporting the existing problems and they closed or lessened the windows of opportunity that invite the development of archaic and maladaptive attitudes that lead to restrictive responses to illness or injury among an older work force. They gained relevant information and used it wisely, and they approached each case with an understanding that each problem is developed within a unique context, therefore each occurrence demands a unique response. They had moved from being a company that was functioning as a hostage to forces outside of their control to one that took control of that which could be contained, designed a communication flow so that it could be aware of those things which were outside of its direct line of influence, and implemented a monitoring, evaluation and refinement process that ensured that the system would be responsive to the needs of both the work force and the company now and in the future.

References

Johnston, W.B. & Packer, A.H. (1987). *Workforce 2000: Work and Workers for the 21st Century*. Indianapolis: Hudson Institute.

Liang, M.H., Larson, M., Thompson, M., Eaton, H., McNamara,E., Katz, R., and Taylor, J. (1984). Costs and outcome in rheumatoid arthritis and osteoarthritis, *Arthritis and Rheumatism*, 27(5), 522-529.

Mitchell, D.K. (1987). The aging workforce and the politics of incapacity, in L.G. Perlman & G.F. Austin (Eds.), *The Aging Workforce: Implications for Rehabilitation*, Report of the Eleventh Mary E. Switzer Memorial Seminar, pp. 17-25, Alexandria, Va.: National Rehabilitation Association.

Sandell, S. (1985). *Older Worker, Prospects, Problems and Policies*, 9th Annual Report, National Commission for Employment Policies, No. 17.

Yelin, E., Nevitt, M., & Epstein, W. (1980). Toward an Epidemiology of Work Disability, *Milbank Memorial Fund Quarterly*, 58 (3).

Excerpts of Reviews and Comments

This paper presents an excellent model for companies who are experiencing problems with health care delivery systems.

The implication that stands out from this case study concerns Empire's health care providers. Instead of being part of the solution for this company, the hospital and other health care providers were part of the problem. This is what forced Empire to take control and invest considerable resources in the process. Employers do indeed play a critical role in the return to work process, as the author suggests, but partnership between employers and health care providers is crucial to meeting the needs of an aging workforce. This is the lesson of the Empire.

Health care service providers should view companies like Empire as their customers in the same way that other companies seek to fully satisfy their customers' needs in the marketplace. This means taking the time and effort to understand the customers' needs and then working with the customer to meet them. This is how everyone wins— the health care provider, the employer and the older worker.

—Linda I. Workman

This was a wonderful, innovative and thought-provoking paper. Dr. Leclair obviously has a substantial grasp of the inner workings of a variety of businesses and is able to bring this to life in this case study approach.

Empire Glassworks is an aging but productive company with an aging workforce. Its workers are its greatest asset and it knows it just like so many other companies today. In recent years it has trimmed all of the "fat" in its operations through downsizing. It noticed an increase in the use of workers compensation, lost days, early retirement applications, and union grievances for inconsistent work practices. It also had a shaky relationship with the mother company due to the above.

The company made a series of moves to correct the identified weaknesses. In every case they continued to support the employees and be honest with them. By working with the unions and not accepting less (or more) than exactly what they wanted from local healthcare providers using internal confidence and understanding that the marketplace will provide what is desired, Empire was able to obtain exactly what was needed. With a well planned approach, good rationale, adequate internal and external components, "trigger points," and flexibility in approach the plan was a resounding success.

The employee sensitive and total human resource development approach appears to be very viable. By not saying that employees were at fault and addressing real problems, real solutions were developed.

This paper echoes the situation of the older worker. A similar approach would bring the older individual back into greater productivity. However, the older individual may have to demonstrate the same internal confidence, focus and ability to deal with those providers offering "package deals" of inappropriate or inadequate service to shape the services offered to meet real needs much as Empire did. There may need to be training or organization to meet this worthy goal. *(The opinions expressed are those of the author and not official RSA positions.)*

—John Nelson

Leclair presents an interesting perspective on a topic that is of obvious importance in exploring the role of the older worker and employment. Utilizing a composite "case" study approach, he presents the "story" of a company's (Empire Glassworks) attempt to work with health care issues.

Particularly significant in the analysis is the need for a proactive, aggressive approach without relying only on health care providers' "packages" and the emphasis on an individualized effort recognizing that the needs for any particular company, industry, or sector of the economy with regard to its employees are different. While the situations may be based upon reality and some very real solutions are presented for handling a changing workforce with regard to intervention, it is also an interesting presentation with its "storybook" ending not unlike that in which everyone lives happily ever after. A thorough critique is difficult because one really cannot argue with success.

Significant issues raised include the need for communication between any company and its employees, the need for adequate education or training efforts for all levels of operations, and finally the need for mechanisms which not only provide fair and equitable adjudication but are perceived as doing so. Unanswered are more specific issues related to specific problems experienced with regard to the workforce, including those that may be related to the specific industry, specific directions for working with persons of different ethnic and cultural experiences, and whether the planned interventions resulted in increased productivity and/or other cost savings/economic benefits. In other words, without specific data, it is difficult to assess what is success. There is clear need for criteria and measurement for evaluation of any intervention.

One important area highlighted by this paper is the need for a more coherent health care policy which would provide for more innovative approaches especially as they relate to the older worker. Interestingly, much of the difficulties involved the lack of application of behavioral science involving attitudes, behavior change, and perception. Research efforts in the social sciences have generally been supported with less resources at all levels of government and the private sector. If "Empire" is a more typical scenario, increased funding into these areas of research would result in substantial payoff.

—Paul Leung

Meeting the health care needs of an aging workforce will require an awareness/initiative and relationships within the organization and with agencies outside the organization, that are not characteristic of employers. But it can be done. It is important to consider that a similarly positive outcome might have resulted at

Empire Glassworks if either the health care providers, the insurance carriers, or the corporate headquarters had been characterized by the commitment, and initiative (i.e., competence) displayed by the individual managers and workers of "Empire Glassworks, Inc." Sad to say, the Empire Glassworks of this world are well advised to not wait for others to take the initiative.

This article has implications for labor management relations, and the delivery of health care services among others. There are however, two central issues to me.

First, the need for people in the health care system, insurance industry, the government, and among employers of all types who have qualities depicted by Empire Glass managers and employees, and an expanded knowledge of what an aging workforce means for society/ and how to constructively build on this reality within their own sphere of responsibility. The primary implications are for an improved education which promotes the personal qualities, knowledge, and decision making skills that lead to smart decisions within a context of personal and social responsibility. Also, we need many individuals in many settings who are better informed about the aging workforce and who are able to translate that knowledge into decisions and actions.

Those within Universities who are responsible for assuring adequate preparation for future leaders, need to assure that an increased sensitivity and knowledge regarding aging issues are an important part of preparation programs. Within every agency involved with employment, health care and rehabilitation, there is a need for education specific to aging and older persons.

The second issue is that an important character is omitted from the fictionalized chronicle of Empire Glass. Government is that major player. Through laws and practices, government creates incentive and disincentive impacting on employers, employees, and all those with parts to play. The government can and should make success stories like "Empire Glass" easier to achieve. Current laws and practices need reassessment to determine how they encourage or discourage the proper and productive inclusion of older persons within the work force, just as is true of handicapped persons of any age. New ways of promoting positive change should be implemented.

—Richard Blake

This paper highlights the salience of the aging workforce in the United States and the value of disability management programs. Through the example posed by the hypothetical organization "Empire Glassworks, Inc.", a very thorough disability management plan for elderly workers is developed. This is an internally developed, proactive plan to meet this challenge at Empire. The plan is developed by management concerned with human resource trends at Empire. Working within a cooperative rather than antagonistic spirit, management seeks the input from health service providers, insurance carriers, unions, and staff members in order to fully understand all problem areas and to identify a corresponding plan of action.

With his example, Dr. Leclair emphasizes the value of a "why not?" and "can do" attitude in addressing a very complex organizational challenge. Instead of responding passively to the negative stereotypes about elderly workers and having external service providers attempt to solve these problems, Empire is portrayed as a company in control of its destiny. Open communication and full participation of all interested parties proved useful. Organizations that believe planning for the challenge of the aging workforce is "something that is done by them" instead of "something done to them," are more likely to be successful.

—James Bordieri

The author provides an excellent success story of how "Empire Glassworks, Inc." deals with problems associated with meeting the health care needs of an aging work force. The model described certainly has implications for the private sector which will be facing a variety of demographic issues that will influence the work force during the 21st century. There are also implications for the health care field in general as it relates to establishing open lines of communication with health care providers and insurance carriers who serve older people in the competitive labor market. The scenario presented illustrates how a private employer can take the initiative and become aggressively proactive in dealing with health care needs of an aging work force. While the state/federal rehabilitation partnership was not mentioned, certainly there will be implications for the public vocational rehabilitation program as it relates to an increased use of the health care system as well as dealing with increased numbers of workers compensation cases. These issues will also have to be addressed by unions and other third parties who in turn will be required to exhibit a higher level of accountability in dealing with such business interactions. The scenario provided serves as an excellent model whereby employers may address their own strategies for meeting the health care needs of their aging work force.

—J. Elton Moore

In "Empire Strikes Back....", Dr. Leclair presents a timely and useful description of a model of accommodation by a company to the needs of its aging workforce. His introduction sets the stage by identifying demographic and general workplace trends such as an aging workforce and greater focus on quality control. Perhaps the greatest contribution of this paper lies in the areas of health insurance and reasonable accommodations.

Dr. Leclair provides a model in which a company problem solves to identify and address the issues underlying decreasing productivity among many workers. Central to the company's findings are issues around their older workers, especially health care and workplace accommodations. To address ageism, the company plans education and training initiatives. Since ageism is so pervasive, these initiatives, in whatever form, are basic meat for the consumer, personnel officers and the general public.

While Dr. Leclair's portrayal of the company's health provider initiative may be a bit on the utopian side, the initiative recognizes that older people have predictable health needs such as those around chronic conditions of arthritis and hearing and visual impairments. This company, as a purchaser of health provider services,

will buy on the basis of the needs of employees. However, Dr. Leclair's company cannot solve the problems of persistent discrimination by the health insurance industry to those with pre-existing conditions or those with rehabilitation prescriptions. Here, only legislation will do.

Dr. Leclair's company may want to broaden its network far beyond the health insurance/provider to, for example, assistive technology. This paper is sensitive to workplace accommodations which will soon be a matter of compliance with Title I of the Americans with Disabilities Act (ADA). Reasonable accommodations and the tandem concept undue hardship are loosely defined in the ADA and extensive litigation is anticipated. Nevertheless, job restructuring and other types of accommodation strategies are included in the ADA. However, the process of supplying an appropriate accommodation is not. Dr. Leclair's company implemented a problem solving approach which would be appropriate to identification of tasks of the work that limit older workers and to identification of accommodations.

—Katherine D. Seelman

Dr. Leclair wins the prize for the cleverest title. It is ironic that in this age of Star Wars we often neglect our very-close-to-earth problems.

I understand that the glassworks is a fictional firm but the solution is very realistic and fruitful.

My guess is that most employers do not know the mean age of their work force.

There are so many positive values in the solution that are worth mention: Reduction in lost work days, increase in the level of productivity and reduction in the use of early retirement.

The question for further research is to discover whether or not there are some standard elements in the Empire solution that could be common to some or all other companies with an aging work force.

It would also be instructive to discover if the Empire experience is unique or if other companies are using an approach like this.

One further question that needs research attention: Does productivity decline with advancing age? If so, at what age is it most pronounced and in what kind of industries?

—Richard P. Oestreich

One Point of View

A Reaction to the Chapters

Paul Leung

Aside from commenting on each individual action paper, I was compelled to try to make some sense of them in totality. I hope that I am not too presumptuous in passing them on. They are merely reactions as I read. There was something very disparate about each paper and yet there were also common themes interwoven throughout.

Clearly, I believe that there are currently more questions than answers. Unless there was a lack of documentation, the papers suggest that there are huge deficits in our knowledge of the concerns and issues related to work and the older worker.

The issues and the interrelationships are immensely complex. I don't pretend to understand them all. But it seems that the data are not even clear or available. Definitions are sketchy and different for each person. There may be a need to design a common starting place though I must admit that it may also be an impossible task. And that in itself is not necessarily bad.

It was interesting that only one paper stressed the importance of allowing the individual to take responsibility and to forge ahead as a strategy that would be effective in creating the energy and the environment resulting in action that changed their lives. As a psychologist, individual empowerment is no stranger and it has an important role. Perhaps the ultimate success or failure of any given individual is dependent on ability to seize the moment or to believe that one has control. But there are some obvious problems that are much greater than the individual and every other writer chose to comment on these external factors and variables.

The call for a wholesale change in society's way of thinking or with its "attitudes" seem to permeate most of the papers. The current structure has perhaps served society well in the past but is no longer adequate for the transition into the 21st century. Several perspectives emphasized the need for education, others called out for a more flexible and equitable approach, some felt that employers needed to be more aggressive in their planning, and still others believe that changes in incentives and in health care policy would create a structure whereby the older worker will be able to be a productive worker.

There were several suggestions that a "developmental" approach (including instructions for the review of papers) be taken. This is something that has been sorely lacking. That is, the tendency is to view one "stage" of life as fairly distinct and, in turn, tends to distort the perspective of variables such as work which are tied to that "stage." I suspect that this is the result of our generally academic way of attempting to categorize things.

One striking omission was a lack of commentary on the role of diverse ethnic and cultural minority persons. Though several implied that these populations are important in the scheme of things, little was developed in the discussions. Demographic trends were cited but strategies for inclusion of these groups were not explored in any detail or with any length. Members of these groups including those who are older will have an important role to play in the workforce and employers and service providers will have to be able to effectively work with persons of diverse backgrounds and experiences.

Policy development in rehabilitation and the older worker appears to be a fragmented enterprise. The papers were very clear on the need to integrate and not look upon each of the areas that impact on the older worker as separate. It may be possible to separate health insurance from the workplace as one author suggests but thinking through all of the implications requires that all facets be brought together. Federal departments who ostensibly work together continue to have differing agendas resulting in programs that may work at cross purposes to each other. Add to that differing local, state, and regional agendas, and it is easy to understand some of the difficulties that need to be overcome for developing coherent policy.

We need to spend some time in filtering out what sorts of data and information are needed to make decisions and policy. The reliance on what feels good and on purely anecdotal evidence will not be sufficient grounds. Application of methodology from areas outside of disability and rehabilitation may be necessary. We will need to expand our spheres of study and to interest researchers who have yet to discover the excitement of rehabilitation issues. The future is a bright one for there are new tools at our disposal. These include various legislative actions such as the Americans with Disabilities Act. There is an increasing awareness of the importance of persons with disabilities and their role in the entire society.

PAUL LEUNG is Director, Division of Rehabilitation Services, University of Illinois, Champaign, Illinois.

Special Invited Paper

Aging with a Disability: Another Advocacy Priority

June Isaacson Kailes

People with disabilities are now experiencing problems that combine the problems of aging with the problems unique to a life spent living with a specific disability.

We have all been told that,"when you get older, you slow down physically, and you can't do as many things as you could when you were younger." For most of us who grew up with a disability and who already couldn't do as much as our peers without disabilities, this warning was rather meaningless.

Others with disabilities who did listen to this warning certainly did not expect that the aging process would be exaggerated. In fact, however, people with disabilities are experiencing unexpected declines in their energy and activity levels as they age. We are exhibiting signs of aging much earlier than the rest of the population our age, yet existing public policy and health and human services are not dealing with this issue.

When I, a person with cerebral palsy, began to articulate my own concerns to friends who were medical professionals, I thought I sounded vague and slightly crazy. When I explained, "I'm not walking as fast as I used to, my balance is not as good as it used to be, and I have more spasticity as well as aches and pain." I did get quite a few blank looks. So I decided to check out just how weird I was by conducting my own very scientific (i.e., informal and undocumented) survey of friends and colleagues with disabilities. My survey results confirmed I was not alone.

After mulling the question over, I chose not to accept my self diagnosis: increasing brain damages secondary to (1) spending too much time on airplanes breathing inadequate, smoke-filled, recirculated air or (2) poor sleeping positions resulting in blood draining from my brain. Given the uniqueness and ambiguousness of these conclusions, I decided to seek some additional professional opinions.

Because I had some background in rehabilitation and neurology, I felt confident that I could make the proper connections. I was wrong! The process was disconcerting, especially given that I live in Los Angeles, not exactly a medically resource-poor area! I found doctors who specialize in children with CP, but I was not able to identify anyone who specializes in adults with CP. After a costly and probably unnecessary MRI of the brain, the most common advice I received was to concentrate on strengthening specific muscles. Other than that, no one had anything very definite to say.

I then sought the help of my out-of-town network and obtained some names. I connected with the doctor whose name was most frequently mentioned when a business trip took me to the city in which he lived. Not only was he very helpful, but he had some very different but specific advice regarding energy conservation, exercise and mobility aids. He felt muscle strengthening would not be that helpful because the unevenness in cerebral palsy comes from imbalance in the degree of damage in the motor cortex. That is, the firing pattern is asymmetrical and it is not going to change. Therefore I could strengthen muscles as much as I wanted but eventually they would return to being unequal in strength. The time and energy were not worth the very temporary, if any, results.

At this point, I felt I had found some answers for myself. But if I had to go through this rather exhausting search for advice and information, I wondered what was happening with others who were asking similar questions. I also wondered what would happen to the upper extremities of others with cerebral palsy who I saw walking so slowing and laboriously on crutches. Was walking so supremely valued by the medical community, parents and society that the long-term effects of wear and tear were better off ignored until they could be ignored no longer?

The 1987 publication of Roberta Trieschmann's important book, *Aging With Disability*, (available from Demos Publications, 156 Fifth Ave., New York, NY 10010) confirmed for me and many others that we were not losing our minds.

Trieschmann substantiated the issue that many of us have creeping into our reality: people with disabilities are now experiencing problems that combine the problems of aging with the problems unique to a life spent living with a specific disability.

The combination of aging and disability is an unexplored, undiscussed and unacknowledged area. Why is this such a new and unanticipated issue? I am told that in the past people with disabilities just never lived that long and thus little is known

JUNE ISAACSON KAILES is a Disability Policy Consultant based in Playa del Rey, California.

about aging and disability. My peers and I are the first generation of people with disabilities who are approaching middle age, retirement and beyond in great numbers. People with disabilities have been taught how to live with a disability but not how to plan to age with a disability nor how to prevent a disability from increasing via the aging process.

Prior to the publication of Trieschmann's book, peer input was the only validation and support people with disabilities had to assure each other that what we were experiencing was something real. Her book also alerted disability advocates that we must make room for yet another issue on our already overfilled advocacy plate. We have to insist that health and social services concentrate a substantial portion of their efforts on the issue of aging with a disability.

Confirmation and Validation

Trieschmann correctly points out that many of us considered our disabilities to be static (spinal cord injury, polio, cerebral palsy, spina bifida). A progressive component to our disability was not anticipated. Now, however, we are experiencing the natural process of aging superimposed on other impairments that have themselves imposed a range of physical, emotional and financial penalties on our daily lives.

Apparently, aging is not only related to chronological age but also correlates with the time since the onset of the disability. Living twenty or thirty years with a disability, depending one's lifestyle, genetic heritage and type of disability, produces wear and tear on the muscles, skeletal system and other body systems. Most people with major physical disabilities of at least thirty years' duration note some tenderness and soreness in joints, muscles and tendons which have been carrying the extra load of impaired physical function from other parts of the body. Heavy use or overuse of parts of the body to compensate for lost motor ability in other body parts can lead to problems over time. As people with disabilities age, the physical penalty increases—and with that goes an often inevitable financial penalty as well.

Why Has This Issue Been Ignored?

Trieschmann explains that rehabilitation is commonly viewed as not a high prestige specialty because it does not focus on dramatic new discoveries leading to"cures." Nor does it focus on the development of new procedures that "solve" problems as do specialties like surgery, cardiology, radiology and oncology. In the medical world, research that's focused on practical issues such as helping people with disabilities lead more satisfactory lives is considered a "weak" science. More prestige is attached to cellular, molecular and biological research, i.e., the "hard" sciences.

Furthermore, rehabilitation medicine continues to focus on acute management of newly acquired disabilities. This focus becomes increasingly weaker when looking at the person who lives with a long-term disability. The gap between the needs of people with disabilities who are aging and the programs in existence to help minimize the impact of the aging process is immense. The research area of "living and aging with a disability" is either not on the list or is a very low priority. The only groups given the slightest attention in the area of aging with a disability are people with spinal cord injuries or survivors of polio. What about people with other types of disabilities? The scope of the research must be broadened.

Obtaining serious input from "users," people with disabilities, is also not on any list. The pattern of professionals determining what services will be given, what research will be conducted, and what type of training will be offered is something that we must impact! We cannot be quiet and invisible any longer!

Research Issues

Research professionals must be convinced that people with disabilities are a large and growing market and that there is a great need for answers to such questions as:

- What is the role of: nutrition, exercise, stress management and other lifestyle issues on aging with a disability?
- In what way do decades of living with a disability alter the general aging process from what it would have been if one did not have a disability?
- Does the presence of a disability accelerate the rate of aging and/or alter the manifestations of the aging process? If the rate of aging for a person with a disability is accelerated, then what specifically is accelerated?
- If aging is different as a result of disability, is it a generalized syndrome that cuts across most disabilities and/or are there specific patterns or problems associated with certain disabilities?
- Is the rate of aging and its manifestations different for those who acquire their disability in early adult years in contrast to those who acquired it in their later years, in childhood, or from birth?
- Is the degree of muscle and skeletal deterioration a function associated with the amount of extra labor, duration of this extra labor, one's general physical conditioning and health, and one's genetic make-up?
- Can the medical records of those who died during successive decades after living with disability be examined to determine if there is a combination of variables, a pattern that differentiates survivors from those who died?
- Can the medical records, including films, of people with CP be studied to determine short-term and long-term patterns of change?

Prevention Research Issues

- What proactive, preventative steps could be taken early in life to prevent or slow the effects of aging with disability?
- What steps can be taken in the early years of disability to prevent or reduce future musculoskeletal problems?
- Is "use it or lose it" a sound strategy, or would voluntary curtailment in the intensity and scope of activities at an earlier age translate into fewer musculoskeletal difficulties in later years?
- Are there trade-offs that need to be decided upon early, i.e., the rigors of walking with crutches in terms of upper extremity muscle deterioration as opposed to using a wheelchair,

particularly if one's career depends on upper extremity muscles?

- At what point should an energy conservation and/or an increased disability prevention program start?
- What is the effect of exercise on preventing disability for specific types of disabilities?
- Is physical conditioning even more important for people with disabilities? Perhaps a decline in energy and strength is accelerated by performing in repeated athletic events (activities of daily living and mobility) without being in proper physical condition.
- Does active and consistent participation in sports for people with disabilities accelerate musculoskeletal difficulties or slow them because of overall physical condition and health?

Nutritional Research Issues

- Do nutritional issues need increased attention for people with disabilities?
- What is the effect of sports nutrition, positive or negative on people with disabilities?
- Are peak performance diets even more relevant for people with disabilities, since living with disability often means continual body strain and stress; i.e., those without disabilities who have been athletic all their lives and who have continued to eat and exercise properly seem to age less rapidly and are healthier than their non-athletic counterparts. What implication does this have for people with disabilities?
- What is the effect of excess body weight on the development of increased impairment?
- Is there increased impact on a person with a disability related to a high fat, high protein, high sugar diet?
- Is calcium supplementation even more important for people with disabilities?

Advocacy Issues

In addition to demanding attention from the research community, we must also muster our advocacy battalions to address the following issues:

- Integrating an aging and disability focus into the practice of allied health profession;
- Reworking and coordinating fragmented social legislation which, although not intended to, keeps people poor and requires that they remain so if they expect any assistance; and
- Demanding an array of community-based long term services that embrace the values of empowerment and self-determination and assist us in continuing to work and to stay in our homes. Community-based long term services, although frequently viewed as just a "seniors issue," is our issue also. If our function declines, we still want to work and to remain independent, free to manage our own lives in our own homes.

In summary, our new awareness of the effects of aging with a disability is accompanied by a growing urgency for information, answers and services. We must be heard and must forcefully demand that the medical, health and social service providers, as well as public policy makers, spend time and dollars on filling the many gaps in knowledge and services surrounding the issues of aging with a disability.

(An earlier version of this article was published in the United Cerebral Palsy Association's January 1990 "Networker.")

Special Invited Paper

Older Workers with Disabilities: A Minority Perspective

Paul Leung

As is readily apparent from the title of this Switzer Seminar and the papers that generated discussion, the primary focus was on older workers with disabilities and their role with regard to the nation's productivity. Several authors commented on the changing demography of American society and on the need to focus attention on older persons and their potential contribution to the work force during the next decade (Morrison, 1991; Sisco, 1991). Given changes in the nation's demography, these authors believe that older persons, including those with disabilities, will have an increased role in the work force because of projected shrinkages in other age groups that have traditionally made up the labor force.

The statistics for an aging population are impressive. Estimates are that there will be 35 million persons age 65 and older by the year 2000, compared to 26 million in 1980. Add to that the "baby boomer" generation born between 1946 and 1964, and there may be 65 million, or 21 percent of the population, older than 65 by the year 2030 (Gaffney, 1990).

Even more impressive is the general aging of the entire work force with estimates that by the year 2000, 51 percent of the work force will be between 35-54 (Jamieson and O'Mara, 1991). An older work force has many implications for public policy as well as for employers. While it would be unfair to equate older age with disabilities, older workers are more likely to experience disabilities and other chronic conditions. For example, chronic conditions frequently associated with aging are arthritis, hypertension, heart disease, hearing impairments, orthopedic impairments, and diabetes and visual impairments (Gaffney, 1990). Thus, the attention of the Seminar on health policy, flexible scheduling, and vocational rehabilitation was expected.

Seminar participants explored some of the problems experienced by the older worker, including problems associated with disabilities. Older male workers with disabilities left the work force at a much faster rate than older workers without disabilities. And people with disabilities were often the first out in declining industries and last hired by emerging industries (National Council on Disability, 1990). Thus, an ongoing theme of the Switzer Seminar was the "double whammy" phenomenon of being older and having a disability.

But for some older workers there is another "whammy" which may bring about even further difficulties— membership in a minority group. As is often the case, the question of minority status was recognized but not dealt with in much detail. Sisco (1991) pointed out that 80% of the net growth in employment will come from minority youth, women, and immigrants and Leclair (1991) in his composite company, portrayed a work force composed of 35% being foreign born. Older workers with disabilities and of minority status must cope with three factors of potential discrimination.

It is the thesis of this paper that minority older workers with disabilities will be important for meeting the work force needs of society in the near future, that there will be a need to recognize and emphasize cultural/ethnic factors in meeting work force requirements, that rehabilitation will have to take race and ethnicity into account with regard to the older worker, and that further research and attention is needed of ethnic/cultural issues related to older workers with disabilities.

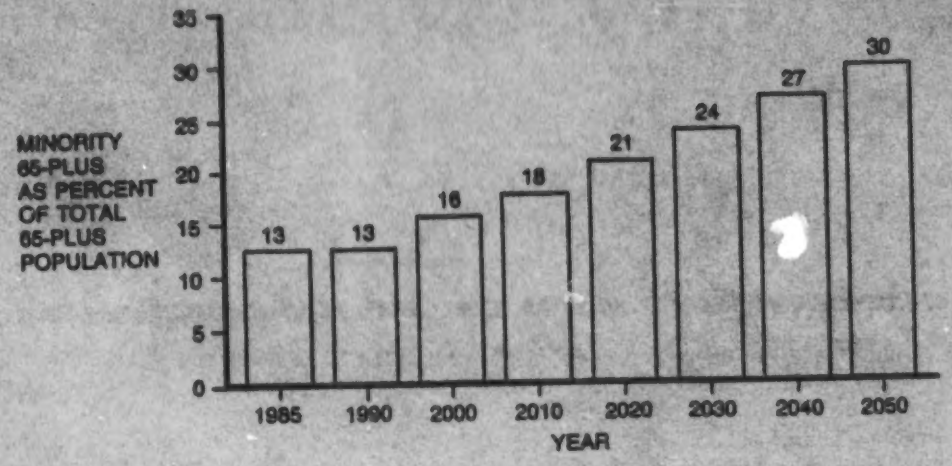
The 1990 U.S. census statistics portray a different America and a much more diverse population than any time in history. The 1990 population figures break down as follows:

- 30 million blacks, an increase of 13.2 percent since 1980;
- 7.3 million Asians, an increase of 107.8 percent;
- 2.0 million American Indians, an increase of 37.9 percent;
- 22.4 million Hispanic people, an increase of 53 percent.
  (U.S. Census, from *New York Times*, March 11, 1991)

There have been significant changes in the racial/ethnic distribution of the population of the United States. As reported in the *New York Times* (Barringer, 1991) the rate of increase during the 1980s of minority populations was nearly twice as fast than in the 1970s. It is clear that the basic nature of the labor force will not be the same as it has been and that changes will be necessary. Several authors of papers for the Switzer Seminar commented on the changing demography of American society and need to focus attention on older persons and their potential

PAUL LEUNG is Director of the Division of Rehabilitation Education Services, University of Illinois, Champaign, Illinois.

Chart 1-3
GROWTH OF THE MINORITY ELDERLY POPULATION:
1985-2050



SOURCE: Spencer, Gregory, U.S. Bureau of the Census. "Projections of the Hispanic Population: 1983 to 2080." *Current Population Reports* Series P-25, No. 995 (November 1986).

contribution to the work force during the next decade (Morrison, 1991; Sisco, 1991).

These statistics would indicate that there will be concurrent growth in the number of minority persons who are considered older workers. The figure above, while specific for those older than age 65, indicates the percentage of growth projected for minority older persons through 2050 at which time minority elderly will be 30% of the total 65-plus population.

Sisco (1991) suggested that increasing numbers of older persons will seek employment because of their financial needs. For the minority elderly, this may be even more critical. Black and Hispanic older persons have lower money incomes than their White counterparts. In 1986 the median income of Black males ($6,757) over age 65 was 56 percent of that of their White counterparts ($12,131). Hispanic males over age 65 had incomes ($7,369) 61% of White males. In addition, poverty rates are much higher among minority elderly than among White elderly (Committee on Aging, 1987-88). The obvious conclusion is that the older minority person is more likely to work out of necessity than the non-minority person. Finally, the incidence of disability is disproportionate for minority populations. Bowe (1985) has noted that minority persons are more likely to work in occupations which inherently involve greater health hazards and risks.

In reviewing these statistics, several things stand out. There is a general lack of available data with regard to older persons of minority racial and ethnic background with disabilities related to employment and labor force participation. Efforts have begun toward building a pool of data by the National Institute on Disability and Rehabilitation Research with the funding of a Research and Training Center at Howard University which focuses on disability and rehabilitation of minority persons. However, the primary emphasis has been on Blacks with some preliminary work on Hispanics. There is considerable need for additional data with regard to other population groups. For example, the fastest growing minority by percentage is Asian. In addition, many of these are immigrants. Yet little has been done in collecting usable data for this population. Because absolute numbers of Asians are small relative to other minorities, currently used sampling techniques may not be adequate in describing the group. Similar problems exist with regard to subgroups of the Hispanic population.

Not only is there need for additional data but there also appears a lack of coordination among organizations which gather various data and in the kinds of data gathered. There appears need for some type of clearinghouse for data related to older minority populations including those with disabilities.

Appropriate planning and policy development must rely on accurate information. The current deficit of data is a barrier toward effective service provision.

Another serious need is for research regarding various racial and ethnic minority populations and employment, disability and rehabilitation issues including older persons. The perspectives and world view (Sue, 1981) of older minority persons with disabilities may, in fact, be different and thus what "drives" them may be different than that which "drives" persons in the majority culture. Thus, rehabilitation and employment practices which are successful for the majority will need to be adapted or modified for minority persons with disabilities for the most cost efficient utilization. For example, basic health care utilization patterns may differ remarkably for reasons such as specific disease and

morbidity incidences, as well as culturally determined views of health, disease, and disability. This will require that employers adapt different models than those that have been traditional.

Cultural and ethnic sensitivity at all levels of the work place is particularly important in creating the climate necessary for older minority workers with disabilities. Industries have recently invested in educational efforts to allow diversity in the work place and to reduce miscommunication due to membership in different population groups. Differences of communication such as the use of body language, eye contact, and appropriateness of touch have different meanings for different groups.

While there is no definitive data supporting a hypothesis of underutilization, there is consensus generally that there is underutilization by members of minority populations of services such as vocational rehabilitation. Full participation depends upon having access or a belief that access is possible. Apparently many minority persons with disabilities still do not feel comfortable with the current system. There are obvious differences of opinion as to why, with some believing lack of participation as attributable to self selection, while others point to an unforgiving environment that does not cater to differences. Outreach efforts, perhaps of a non-traditional nature, should be expanded to reach these often isolated minority groups. Some of the usual methods utilizing media to reach minorities do not appear to be successful. Access to training opportunities or participation in the vocational rehabilitation program involves trust of the system that many older minority workers with disabilities currently don't have.

There are specific educational needs that need to be met with regard to professionals and other personnel who serve these populations, as well as persons who have disabilities. Education cannot be limited to traditional models, but needs to be expanded to reach a much wider audience. More specific efforts toward targeted population groups will need to be made if there is to be an impact. Some of the energy that advertising has spent toward developing media packaging with specific minority populations for products could be well spent in attempting to reach those persons who have given up in their search to be productive workers, even though they may be older and have a disability.

In summary, any discussion of older workers with disabilities must include persons of minority background, as they are, and will continue to be, a significant force during the next few years. Much more attention will need to be given minority populations from both the public and private sectors if their talents are to be fully utilized in the American work force of the future.

References

Barringer, Felicity. "Census shows profound changes in racial makeup of the nation." *New York Times*, March 11, 1991.

Bowe, Frank. *Black Adults With Disabilities*. President'sCommittee on Employment of the Handicapped, Washington, DC, 1985.

Gaffney, James. "Growing old, getting fit." *Rehabilitation Management*, Oct./Nov., 1990, pp. 43-49.

Jamieson, David and Julie O'Mara. *Managing Workforce 2000*. Jossey-Bass. San Francisco, 1991.

Leclair, Steven. "Empire strikes back." Paper presented at the 15th Mary Switzer Seminar, Washington, DC, June 1991.

Morrison, Malcolm. "Employment of older workers with a disability: Attitudes and legal issues." Paper presented at the 15th Mary Switzer Seminar, Washington, DC, June 1991.

National Council on Disability. *Focus*, Fall, 1990. "Employment issues of people with disabilities after ADA."

Sisco, Kathy. "Employment of the older worker with a disability." Paper presented at the 15th Mary Switzer Seminar, Washington, DC, June 1991.

Sue, Derald W. *Counseling the Culturally Different*. John Wiley and Sons. New York, 1981.

U.S. Senate Special Committee on Aging. *Aging America: Trends and Projections*. 1987-1988 edition.

Special Invited Paper

Aging, Habilitation, and Persons with Developmental Disabilities

Richard J. Coelho

America is becoming an aging society. The number and proportion of older persons within the American population are increasing steadily and at a faster rate than other segments of the population. Projections suggest that by the year 2000, over one-fifth of the population will be age 55 and over. By 2010, older persons in this age range will account for one out of every four Americans. This population shift, particularly as it includes older persons with specialized care needs, will place considerable demands upon the health care system, seriously affecting the nation's economic, social, and health institutions and services.

The implications of an aging population on rehabilitation services for persons with disabilities now places the field of rehabilitation at a major crossroad. Traditionally, vocational rehabilitation services have been devoted toward aiding persons with disabilities to enter the competitive work force. However, projected work force demographics now show that, while the number of older workers 45 years and older is increasing, the number of younger workers in the 18 to 34 age group will decline. Also, the proportion of the population that leaves the work force due to disability will increase.

Persons who are older comprise most of the population of persons with disabilities. Furthermore, over fifty percent of the workers with a disabling condition are persons age forty-five or older. One aspect of this reality is that older persons are expected to seek assistance from our nation's vocational rehabilitation services.

Therefore, the rehabilitation service system will need to change and clarify its commitment to older persons with disabilities, especially those with a lifelong disability. The historical focus has been on aiding persons who were younger in age who showed "employment potential." This has meant that persons with developmental disabilities, in late-middle age, have not been the primary focus of vocational rehabilitation. As a result of the expected changes in U.S. demographics, and an awareness of the need to offer viable options to persons entering this older age group, the rehabilitation service system must re-examine its mission.

Just as the general population of older persons is increasing in number, so is its sub-group of persons with developmental disabilities. Increased life spans paired with an improved quality of life are due to shifts in treatment philosophy, improvements in medical and habilitation technology, and progress in community based service delivery.

The developmentally disabled include persons with severe and chronic disabilities, manifested before age twenty-two, which result in substantial functional limitations in three or more major life activities, such as self-care, learning, and economic self-sufficiency. By definition, these persons need a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

For older persons with developmental disabilities, employment options, retirement options and flexible day activity participation schedules are restricted or hindered. This has resulted, in part, from national standards that require persons living in community group homes to attend full time day programs. Many older persons live in community residences that are not funded for staffing coverage during the day. This requirement has inhibited the development of creative options that integrate retirement activities with forms of employment.

Given the physical and social attributes connected with aging, concerns arise from the use of current models of "active treatment" for persons who are aging with developmental disabilities. In addition, federal standards require a minimum number of hours in active treatment to which programs must conform. For persons who are aging with developmental disabilities and attending day services, these standards will need to be flexible to allow active participation in typical community adult programs by persons who are aging with developmental disabilities, but at a less intense level of involvement or duration. To address the range of services required to respond appropriately to the diverse needs of this population, there must be policy changes. These changes would include a shift from scheduled or fixed day program participation to less regular, more individually tailored day program schedule.

RICHARD J. COELHO is with Clinton-Eaton-Ingham Community Mental Health Board, Community Services for the Developmentally Disabled, Lansing, Michigan.

Direct experience with persons with developmental disabilities has shown that many wish to continue working, even if reduced to part time work because of the benefits that income and social relationships offer them. Others, who have not been employed, if given the option, may want vocational training to become competitive workers. Unfortunately, rehabilitation service agencies have rarely focused on older persons with disabilities as a client population. Employers in the future will begin to seek alternative workers, particularly to address the decrease of potential workers available in many service occupations. It is likely that older workers, with and without disabilities, can help to fill this gap.

If older persons with developmental disabilities are provided a range of meaningful and realistic programming options, they can make choices regarding the activities they wish to pursue. Their lives need not be restricted to the routines of prevocational workshops or adult day activity programs. These older persons are entitled to enjoy the same dignity and respect deserved by all persons in society, having a right to choose options such as to continue to be educated, to enhance or reduce their involvement in work, to relax, to volunteer their time, to engage in religious activities, or to take part in recreational activities. Full retirement, with carefully planned opportunities for new experiences, personal growth, and learning, should be available to all who choose it.

An increasing body of knowledge suggests that older persons with developmental disabilities have much in common in characteristics and service needs with its age peers without developmental disabilities. Therefore, coordinated planning between the rehabilitation, developmental disabilities, and aging network systems to maximize the inclusion of these persons into programs and services offered in the community is desperately needed. Persons who are older with developmental disabilities are entitled to the same array of community health and social services available to other older persons. Experience shows that the needs of some of these older persons may be appropriately met by generic social services or aging programs; however, the needs of others may be better met by specialized developmental disability service providers or by a combination of service sectors.

The changing demographic nature of our society poses difficult challenges for the field of rehabilitation. Rehabilitation professionals, especially rehabilitation counselors must be trained and prepared to act both as a supplier of the needed services and as advocates for the developmentally disabled within the greater aging and rehabilitation service networks. Therefore, rehabilitation counselor education programs should offer courses and training in aging and aging counseling, with a focus area on developmental disabilities. This training in gerontology and developmental disabilities, along with an increased experience with the community network of service resources for older persons is required so that full inclusion takes place.

Rehabilitation professionals are urged to take a proactive role in initiatives that will foster future social policy for the delivery of community based services to this segment of the aging population with disabilities. The field of rehabilitation is now in a position to impact on the growth and development of innovative service options for older persons with developmental disabilities. Maintaining older persons with developmental disabilities in a productive life with independence and inclusion within the community is an exciting rehabilitation challenge.

References

Coelho, R.J. & Dillon, N.F. (1990). A survey of elderly persons with developmental disabilities. Journal of Applied Rehabilitation Counseling, 21(1), 9-15.

Coelho, R.J., & Dillon, N.F. (1990). Older adults with developmental disabilities: An interdisciplinary approach to grouping for service provision. Western Reserve Geriatric Education Center Interdisciplinary Monograph Series, Cleveland: The Geriatric Education Center.

Special Invited Paper

A Tri-Center Approach to a Unique Dichotomy

Spencer Bartley

Statistics paint a bleak picture for the future. Workforce 2000 does not look good. Frighteningly, many of us who thought we were still young have entered the "prime-time plus" category.

What do we do? Do we take early retirement, sit on our back porch (if we can afford one), and take our benefits (if they still exist)? Do we go back to work, get retrained, or become rehabilitated? Why not just pull the plug? Why look for solutions?

There is a unique dichotomy in this scenario. Decreasing resources among the young require increasing resources from mature adults. Lack of skills in our youth necessitates reinvolvement of our seniors. Lack of experience requires experience. Turning off means reaching out. Underdeveloped opportunities need to go to our greatest under-utilized resource— the mature adult.

The answer to this dichotomy lies within our own research— partnerships, coalitions, resources coming together to fit need to need. Need for involvement matching need to have involvement. Need for experience matching need to share experience in a positive, supportive environment.

The phrase "success breeds success" is based upon the finding that achievement is the greatest contributor to high self-esteem. To build success, the home, businesses and community must come together to provide supportive environments for growth and creative opportunities for positive achievement. Congress has recently recognized, through the Americans with Disabilities Act, that the total community must provide opportunities to those with special needs if our nation is to meet its goals for the future.

An exciting organization, POWERS Coalition, Inc., has emerged as a dynamic force in developing community-wide networks of support for special needs populations. POWERS is a true example of a successful partnership between the public and private sector. The organization's core belief is that by reaching out to special populations, one-by-one, the barriers preventing success on the job or in the development of life skills can and will be eliminated.

SPENCER BARTLEY is a Division Recruiter with the Southland Corporation, Alexandria, Virginia.

The POWERS mission is to facilitate the development and implementation of opportunities, programs and services for the education, motivation, training and job placement of persons with special needs and disabilities. POWERS serves as a single point of entry to a network of existing and rapidly expanding resources. The POWERS Coalition includes educational organizations, businesses, community agencies, governmental services, and individuals.

POWERS programs currently operate in more than 16 POWERS Centers in Maryland, Virginia, and the District of Columbia. POWERS Centers are specific locations such as schools, businesses, or agencies that successfully bring together creative approaches and resource networks for the education, training and employment of special needs populations. Approaches utilized in the Centers include individual skill assessment, tutoring, mentoring, role modeling, motivational activities, and career orientation/training/placement programs.

Current plans for expansion include the introduction of mobile POWERS Centers that will take educational, counseling and career services directly to special needs individuals within the community. The mobile Tri-Center concept, developed by Dr. Susan H. Wilson, Vice-President of POWERS, is designed to provide a coordinated approach to addressing immediate and long term needs of the mature American. It is designed to provide one location, a single point of entry, for individuals to meet with a caring staff who will work with the person and family to identify the problem(s) and to develop a strategy for solutions.

The program will include three Service Centers: (1) The Education Service Center, (2) the Life Skills/Counseling Service Center, and (3) the Career Service Center. The program will coordinate with the home, businesses and community agencies to address immediate needs, to provide options for short-term service and to develop long-range plans for change. The staff will be able to provide educational, counseling and career services at the three Service Centers, as well as to coordinate services with other businesses and agencies in the community. The program will also be a central location that individuals, agencies and businesses can contact to provide services and to establish opportunities for training and employment.

In addition to providing services, the program will include training for staff, families, businesses and community representatives in establishing partnerships, developing new skills, building self-esteem, developing positive relationships, planning for change, creating opportunities for achievement and meeting special needs. Training will be a key component for generating positive opportunities and environments for success in homes, businesses and communities.

Through the mobile Center vans, the program will provide services to special needs individuals within a facility, as well as outreach services to the community. During the day, for instance, the Tri-Center can provide alternative educational/employment programs and services to adults at a specific site, including diagnosis of needs and development of specific programs for implementation. During the afternoons, evenings and weekends, the Centers can be available for services to participants, families, other members of the community, or people with special needs. The mobility of the Tri-Center will facilitate the implementation of the outreach program.

The goal of the Tri-Center Program is to address the challenges faced by special needs populations in entering or re-entering new life situations or career fields. These challenges include loss of self-esteem, increase of physical disabilities, loss of mobility, reduction of opportunity, and decrease of support. The Tri-Centers will take resources and opportunities directly to the person in need of service.

No longer will lack of opportunity, resources, or mobility be an excuse for failure. As my grandfather said, "There is no lack of resources, only of resourcefulness."

Special Invited Paper

Wanted for Work: Mature Employees

Samuel R. Sacco

The trend in recent years has the average retirement age dropping from about 65 to almost 60 in spite of increased life expectancy. The younger age at which people are retiring, coupled with a population aged 50 and older which is increasing at a faster rate than other age groups, means that more and more people are joining the ranks of a retired, leisure class than are entering the workplace.

Yet, a poll by the American Association of Retired Persons found that those aged 55 to 64 prefer work to retirement by a three to one margin.

But then the question arises — why do most people retire? Because they *want* to? No. Because they *have* to? No. Because they *can*? Yes.

As the population remains more physically active later in life than ever before, many mature men and women feel that *total leisure* is not the lifestyle that they want for the 20 or 30 years after retirement. After an active career — and the lifestyle that goes with it — the sense of emptiness and loss of purpose can be significant. Many miss the companionship of coworkers and the feeling of accomplishment.

However, just because older people may not want to take on a life of complete repose and non-work, it doesn't follow they want to continue with a 40-hour workweek on a regular, permanent basis. Those drawbacks include limited time-off, pressure to perform, and the physical requirements involved, even if it's just getting up and going to work every day of the year.

A solution that some, but not enough, older Americans have discovered is working as a temporary employee. In 1989, only 9% of the temporary workforce (which numbered more than one million in 1990) were 55 or older and only 12% had retired from a full time job.

Due to the inherently flexible nature of temporary help, older Americans find it very attractive, especially in terms of work load, scheduling, and skills needed. This kind of flexibility means that the lengthy trip which was always dreamed about and planned for can be taken because there are no obligations or commitments, except, of course, to complete an assignment. The temporary help industry recognizes that older workers represent a vast repository of skills, knowledge and expertise. Many temporary help companies, in fact, have specific programs to aid mature workers in re-entering the workplace. Temporary help can be the best choice between full-time work and full-time retirement.

Market research professionals, demographic experts, and human resource executives all agree that the shortage of skilled workers in this country will continue to unfold as the workplace becomes more complex and the population's demographic curve shifts. Their beliefs only differ regarding the severity, timing, and potential solutions.

Changing attitudes about older workers are causing businesses to re-evaluate their personnel policies. Older workers are finally being perceived as valuable personnel resources who bring much needed stability, wisdom and talent to the workplace. Barriers that used to impede continued employment for those who wish to work beyond "retirement age" are beginning to be eliminated. Both temporary help companies and their clients realize that the older worker's job experience and desire to work will make him or her a more reliable worker. A large number of temporary help company customers prefer older workers because they are quality-oriented people who take great pride in their work.

Recently, the Commonwealth Fund, a New York-based philanthropic foundation, released statistics which strongly support the thesis that older workers are superior based upon their own data and information supplied from Days Inns' reservation center. Senior workers, which were defined as employees over 50 years of age, were absent less (1.7 percent vs. 3.7 percent), costs less to train ($584 vs. $1,646) because of lower turnover (average tenure of employment for older employees was three years vs. only one year for younger employees), and even had lower health insurance costs ($1,463 vs. $1,552). Regarding productivity, during the first six months on the job in the Atlanta reservations center, 43 percent of the rooms were booked by older workers but only 38 percent by younger employees.

The exceptional growth for the relatively new temporary help industry can be attributed to this sought-after flexibility by the workforce, the four to six week gap it takes to hire the right full-time employee, as well as business achieving a better understanding that employee skills should be managed just like any other company resource.

SAMUEL R. SACCO is Executive Vice President, National Association of Temporary Services, Alexandria, Virginia.

With an annual payroll of an estimated $10.1 billion in 1990, there are more than 12,000 separate temporary help offices in this country plus many thousands in Canada, Europe, and the Pacific Rim. Temporary help firms now provide jobs for more than one million people per day in the U.S.

And what kind of job might an older individual expect to get through a temporary help company and for how long? The major categories are office work (such as clerical and data processing), 63%, and light industrial (manual labor and factory assembly workers), 15%. The temporary help industry is also expanding to include professional and technical skills (accountants, paralegals and lawyers, CPAs, mid and upper level managers, engineers, drafters, designers, marketing professionals, writers, graphic artists), 12%; and medical jobs (mainly nurses and nurses' aides), 10%. The length of assignment can be anywhere from a half day to a year or longer, with the average assignment two or three weeks in duration.

The variety of assignments means that the temporary employee doesn't get "stuck" in the same old routine. Temporary help companies work with their employees to match their specific skills and interests to a customer's needs, but in the end, the temporary employee is the one who decides on a particular assignment.

The potential temporary employee with immediate marketable skills (i.e., engineering, word processing) should also inform the temporary help firm if other types or a variety of jobs are desired. Most temporary help companies provide training and cross-training sessions to their temporary employees to increase the skills available for assignments. The pay varies depending upon the applicant's level of experience and the local market demand for the type of services desired. In many cases, the pay is comparable to an equivalent full-time position.

For the older American exploring the temporary help option, the most important thing to remember is that the temporary employee is on the payroll of the temporary help firm. Therefore, he or she is not charged a fee, works at an hourly rate which is agreed upon in advance, and only needs to accept assignments which are desired. It is not considered a "black mark" against the temporary employee if they don't want to work during a period which an assignment is offered — the good employee will be called again and again. The only responsibility to this wonderful flexibility is that the temporary employee is expected to complete the assignment once it is accepted.

Temporary help services pay all the mandated taxes— Social Security, unemployment compensation, workers' compensation, etc.— and track year-to-date earnings. Another important consideration is that the retiree does not have to "retire completely" to keep receiving Social Security benefits. There are no penalties or restrictions placed on Social Security earnings up until a certain level. At that point, many simply stop accepting temporary help assignments when that earnings level is reached. As a matter of record, NATS is an active supporter of the "Older Americans' Freedom to Work Act" which would repeal those restrictions.

Fringe benefits such as vacation pay, health insurance, etc. varies from one temporary help firm to another. In addition, all temporary help firms have agreements with their client companies regarding procedures to follow if a permanent job situation is desired by both parties.

In summary, because of the growing worker shortage, industry needs to invest time and resources to retain or recapture skills and people power. Currently employed people approaching retirement age, as well as those who are presented with early retirement packages, need to consider and plan for a reduced schedule instead of total retirement so they can pass on their lifetime of experience.

Special Invited Paper

Older and Younger Workers with Disabilities: Shared Needs and Disjointed Policies

Katherine D. Seelman

Introduction

The Americans with Disabilities Act of 1990 (ADA) has inspired optimism about equity in employment and accessibility of public services and transportation, public accommodations and communications for individuals with disabilities. Yet there is also considerable discussion about limitations on the impact of the ADA, especially in employment. While the ADA has certain inherent limitations, these discussions focus more on the limitations imposed by the larger disability and aging policy frameworks, portions of which are not in harmony with the ADA. These limitations are the subjects of future disability policy since they have profound implications for equity and the productivity of workers with disabilities.

The ADA has begun to generate speculation that the law will not be vigorously enforced (Scotch, 1991) and that loosely defined terms like reasonable accommodation will result in endless litigation (Weirich, 1991, Tucker, 1991). The ADA also has some notable gaps, such as substantial protection against discrimination in health insurance (National Council on Disability, 1990) and the civil rights implications of assistive technology (Morris, 1991). These examples refer directly to the ADA, but also are notable for their conflicting value premises and lack of coordination among implementing agencies such as vocational rehabilitation and social security. DeJong (1991, p.1), who recently likened disability policy to a "three-legged stool," described the three components as follows:

- Civil rights protection such as those provided in Section 504 of the Rehabilitation Act and the recently enacted Americans with Disabilities Act.
- Skill enhancement programs such as education and rehabilitation; and
- Income and in-kind assistance programs such as the DI and Medicare programs.

DeJong (1991, pp 1-2) argues that the 75 percent unemployment rate of working-age individuals with disabilities is related to deficiencies in the income and in-kind assistance programs. While medical impairment is central to receipt of benefits in these programs, medical condition has become less relevant in determining a person's ability to work. A parallel exists in aging, with the Age Discrimination Act of 1990 (civil rights), the Older Americans Act of 1965 (skill enhancement, etc.) and various income and in-kind assistance programs such as Medicare. While some pieces are in place, disability and aging have, as yet, failed to establish an authoritative and integrated social policy based on principles of independence and community integration. This social policy would replace a hodgepodge of policies, some of which are based on principles of dependence and separatism. In the absence of an integrative and authoritative social policy, individuals with disabilities will be faced with formidable problems in the workplace. The social support which they need to do their work may not be available; support in the way of income programs and institutionalization may be available. These issues, so important to equity and worker productivity will be revisited with greater specificity.

Background

Representatives of the aging and disability constituencies at the National Conference on Disability and Aging of 1985 (Mahoney, Estes and Heumann, 1985) foretold many of the problems which continue to face these groups today. According to Carroll Estes (Mahoney et al., 1985, p. 4), a specialist in aging, both groups share the problem of living in a society that has no universal health care coverage—a society in which health care emphasizes acute care and is insensitive to chronic illness needs. Estes notes that both groups have been stigmatized and that society tends to allocate more medical resources and fewer social resources to people who are stigmatized. Judy Heumann (Mahoney et al., 1985, pp. 11-12), an expert in disability policy, expressing her concern that older disabled people should be enabled to live independently, argued that social policy and private insurance must address the need for personal attendant services. Alexandra Enders (Mahoney et al., 1985, pp. 64ff), an assistive technology expert, made the following observations:

KATHERINE D. SEELMAN is a Research Specialist at the National Council on Disability, Washington, D.C.

When discussing the issue of providing services needed by the elderly and the disabled, in the home and in the community, applicable technologies can easily be seen as "tools for living in the community." Common sense and practical experience tell us these are not medical appliances. However, it is dangerous to acknowledge that these devices are not really health care/medical technology. Much of the third-party reimbursement for them is based on meeting the criterion of "medical necessity."

The availability in the workplace of health insurance, personal attendant services and assistive technologies are crucial to employment opportunities and work productivity for workers with disabilities. Each area is vulnerable to legal challenge in order to clarify the employer's responsibility for reasonable accommodation or, in the case of health insurance, to test the ADA's promise of equal benefits within the constraints of underwriting risks.

Disabled Workers and Health Insurance

The Americans with Disabilities Act, as originally conceived, provided protection from discrimination in health insurance. However, this provision was subsequently dropped due to political pressure. (National Council on Disability, 1990) Title I of the ADA indicates that discrimination includes denial of benefits. However, Title V(c) states that Title I - IV shall not prohibit or restrict insurers from underwriting or classifying risks. These provisions of the ADA will undoubtedly have their day in court. In the meantime, individuals with disabilities who are working or are desirous of working will continue to experience a complex array of problems. These problems include: pre-existing condition clauses, exclusions, substantial co-payments, caps and waiting periods. (Gris, 1988-1990) Workers with disabilities who have coverage will be constrained to remain in their jobs rather than risk losing their health insurance coverage in a move to a new position or to a part-time job.

Since older individuals and individuals with disabilities have particular needs, such as medication, rehabilitation, assistive technology and personal attendant services, they may opt out of the labor market if public health insurance provides more adequate health insurance coverage. A U.S. General Accounting Office (GAO, 1987) report supports these observations as well as earlier observations by DeJong about work disincentives within income support programs. GAO found the following:

- the majority of SSDI beneficiaries were either too old for vocational rehabilitation (VR) services or unlikely candidates;
- in 1986 only 1 percent of the persons who became beneficiaries in 1983 left the benefit rolls to work and less than one-third of those had received VR services;
- nearly two-thirds of the beneficiaries with VR services obtained them at an agency before receiving benefits;
- many beneficiaries who completed VR programs either received less income than their SSDI benefits or not enough for them to give up their benefits;
- most beneficiaries were afraid of losing their Medicare benefits, since they would not be able to replace them with other insurance;
- although current work incentives were helpful to beneficiaries who were anxious to return to work, they did not induce others to attempt working;
- more beneficiaries would attempt to work if their benefits were continued on a sliding scale based on earned income.

While the Social Security Administration has attempted to address some of these issues, the problems continue to exist. In addition, the disability policy framework does not provide for adequate coordination among agencies nor has it provided services sufficient to actively identify and meet the needs of severely disabled and older workers.

Assistive Technology and Personal Attendant Services

Assistive Technology

Technology in the workplace can provide accommodations which enhance the productivity and integration of older and younger workers with disabilities. For workers with functional limitation related to cognition, hearing, vision, speech or dexterity, technology accommodations will constitute a major support for completion of work tasks. The Congress has recognized the central importance of assistive technology through the passage of many pieces of legislation over the last decade. Acquisition or modification of equipment and devices is a mandated approach to reasonable accommodation under Title I of the ADA and the implementing regulations for Section 504 of the Rehabilitation Act. The most recent amendments to the Older Americans Act of 1965 added a definition of assistive technology to Section 102. (U.S. Congress House of Representatives, 1987) The Technology-Related Assistance for Individuals with Disabilities Act of 1988 provides for state programs and for technical assistance, but does not fund assistive technology nor does it appear to serve a significant part of the elderly constituency.

In testimony presented at a National Council on Disability hearing on the reauthorization of the Rehabilitation Act, Section 508, Michael Morris (1991, p. 3) described the issue of access to technology as follows:

...a combination of improved awareness and information channels, peer support, available professional experts, funding and product design improvements over the life span of an individual.

While each of these issue areas deserves further resource allocation and program coordination, the problem of funding is tantamount to the other issues. (U.S. Congress, Office of Technology Assessment, 1982) Older workers, for example, will not receive a hearing aid as a reasonable accommodation under the ADA and Medicare does not cover hearing aids (U.S. Congress, Office of Technology Assessment, 1985). Vocational Rehabilitation, an important source of funding for assistive technology in the workplace, has not routinely served severely disabled and older individuals.

ADA regulations may address the problem of inaccessible public technology such as the automatic teller machine or, in fact, any public information center. However, Section 508 of the Rehabilitation Act has only touched the tip of the iceberg in product design and federal procurement policies related to workplace equipment. Workers with disabilities will benefit from

products that are designed to meet the widest range of abilities. As civil rights issues and access issues converge, social policy will be challenged to decide whether assistive technology is an entitlement which empowers individuals with disabilities to expression of full citizenship, including equal opportunity in employment. (Morris, 1991)

Personal Assistance Services

Personal Assistance Services (PAS) usually refer to interpreter services, reader services and personal attendant services for persons with functional limitations related to cognition, dexterity, hearing, speech and vision. Interpreters, readers and equipment are named as auxiliary aids and services in Section 3 (1) of the ADA; personal attendants are not named. Homecare is named in sections 307 (26-27) and 341-342 of the Older Americans Act, but, in sections 341-342, home aides are linked to "frail" older individuals. Clearly workers with disabilities would benefit from a coherent national PAS policy which would allocate both financial and service resources in a rational and predictable manner to those who need them to realize their civil rights. Studies such as *Attending To America: Personal Assistance for Independent Living* (Litvak, Zukas and Heumann, 1987) document the need for a national PAS policy.

Conclusions

The impact of the ADA on employment will be limited by the disjointed aging and disability policy framework as well as by gaps in the ADA. Health insurance and health-related services, including PAS and assistive technology, are resources which are still allocated by a policy based more on medical criteria and dependency principles than on a social model based on principles of independent living and community integration. Whether a social model can serve as the core of the disability and/or aging policy framework in the absence of guaranteed minimum income, is an intriguing question for those who support the transition of people from client status to the status of consumer and worker.

References

Age Discrimination Act of 1975, P.L. 94-135.

Americans with Disabilities Act, P.L. 101-336.

DeJong, G. (1991). Bringing the Social Security Disability Insurance Program into the 1990s. Testimony before the Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C. Hearing on The Need for Structural Reform of Social Security Disability Insurance. June 25, 1991. 1-6.

Gris, B. (1988-1989). *Access to Health Care*. World Institute on Disability, Berkeley, Ca. 1 (1-4), 1-64, 1-91.

Litvak, S., Zukas, H. & Heumann, J.E. (1987). *Attending to America: Personal Assistance for Independent Living*. Berkeley, Ca.: World Institute on Disability, 1987. 1-169.

Mahoney, C.W., Estes, C.L. & Heumann, J.E. (1985) Toward a Unified Agenda. *Proceedings of a National Conference on Disability and Aging*. Sponsored by Institute for Health & Aging, University of California, San Francisco and World Institute on Disability, Berkeley. Wingspread Conference Center Racine, Wisconsin. 1-137.

Morris, M. (1991). Statement presented at the National Council on Disability Hearing on the Reauthorization of the Rehabilitation Act: Section 508. June 10, 1991. 1-5.

National Council on Disability (1990). National Council on Disability Study of Health Insurance for Persons with Disabilities. Project Description. Washington, D.C. 1-2.

Older Americans Act of 1965 as amended, P.L. 89-73.

Rehabilitation Act of 1973 as amended, P.L. 93-112.

Scotch, R.K. (1991). The Impact of Civil Rights Legislation on Employment for Americans with Work Disabilities. Presented at the Fourth Annual Meeting of the Society for Disability Studies. June 26-29, 1991. Oakland, California. 1-15.

Technology-Related Assistance for Individuals with Disabilities Act of 1988, P.L. 100-407.

Tucker, B.P. (1991). The ADA: A Legal Perspective. Presented at the Fourth Annual Meeting of the Society for Disability Studies. June 26-29, 1991. Oakland, California.

U.S. Congress, House of Representatives 100th Cong. 1st sess. (1987). *Older Americans Act Amendments of 1987: Conference Report*. Report 100-427, November 9, 1987.

U.S. Congress Office of Technology Assessment (1985). *Technology and Aging in America*. (OTA-BA-264) Washington, D.C., 1-496.

U.S. Congress Office of Technology Assessment (1982). *Technology and Handicapped People*. (OTA-H-179) Washington, D.C., 1-214.

U.S. General Accounting Office. (1988) *Impact of Vocational Rehabilitation Services on the Social Security Disability Insurance Program*. (T-HRD-88-16) Washington, D.C.

Weirich, C.G. (1991). Reasonable Accommodation Under the Americans with Disabilities Act. *The Labor Lawyer, 7* (1), 27-36.

(This paper does not necessarily represent the views of the National Council on Disability.)

Special Invited Paper

Union-Management Cooperation for Implementing the ADA

Guy Stubblefield

I have organized this paper around two points. One, how trade unions can be used as a resource in the community for implementing ADA and secondly, how I see ADA effecting the relationship between companies where a collective bargaining agreement exists and the union that is a party to that agreement.

The passage of the Americans with Disabilities Act (ADA) on July 26, 1990, is designed to provide significant new opportunities for people with disabilities to engage in employment in an equitable manner in an integrated setting with non-disabled persons. Therefore, ADA is a challenge to labor unions and employers alike to take action to eliminate discrimination in the world of work.

The Americans with Disabilities Act of 1990 gained significant, and in fact majority support, from both political parties in the Congress and was signed by President George Bush. This establishes a major bench mark in the long progress toward equality, fairness, and justice for persons with disabilities.

It presents both a challenge and an opportunity for organized labor as an advocate of worker rights in partnership with management to address the problems of this special population, many of whom have been living without jobs and the necessities of life that can be provided only with financial resources that a job provides.

The Labor Union Commitment

Labor unions have a tradition of representing the worker: we have historically fought for their rights and for safe and healthy work environments, and advocated for good jobs, good pay, and good benefits. That role has always included assisting workers (union members) who had become disabled and were seeking to return to work. That special role has now expanded under recent policy changes to include helping people with disabilities make the initial entry to the job market. ADA will further increase that involvement.

GUY STUBBLEFIELD is Assistant to the President, International Association of Machinists, Center for Administering Rehabilitation Employment Services, Washington, D.C.

Labor union contracts cover an estimated 17-18 million workers employed in a variety of settings throughout the United States and represent a relatively untapped resource in developing employment for persons with developmental disabilities as well as workers who become ill or injured on the job and lose their job as a result of no accommodation being made for their disability.

"The involvement of labor unions in promoting and advocating for jobs for persons with disabilities is encouraged by the adopted policy of the parent body, the American Federation of Labor-Congress of Industrial Organizations (AFL-CIO)." (Whitehead). This policy is summarized by a statement from AFL-CIO President Lane Kirkland:

"The AFL-CIO firmly supports the rights of workers with disabilities to be treated with dignity and respect in their working lives. The Federation and its 90 affiliated unions work through legislative channels and collective bargaining agreements to assure equal opportunity for all workers with either mental or physical disabilities."

Additionally, it should be noted that 31 international unions that are affiliated with the AFL-CIO are members of the President's Committee on Employment of Persons with Disabilities. Leonore Miller who is President of the Retail, Wholesale, Department Store Union is currently a vice president of the President's Committee. Charles E. Bradford of the Machinists Union and Michael G. McMillian of the Human Resources Development Institute AFL-CIO are members of the executive committee of the President's Committee. There is a labor committee of the President's Committee consisting of designated representatives from among these 31 international unions and this committee is currently chaired by yours truly beginning in May 1991. I mention these things to illustrate the very sincere and deep involvement of the labor movement as an advocate for persons with disabilities even before ADA became the law of the land.

Before I go further, I would like to suggest to you, that there are two ways to approach the implementation of ADA. By the way, this applies to both unions and employers. One approach would be to carefully fulfill the requirements of the law "even though grudgingly" in an effort to avoid penalties, liability suits, or perhaps prison. But a far better way would be to react as good

citizens in the communities where we live and work to do in the words of my good friend, Justin Dart, Chairman of the President's Committee on Employment of Persons with Disabilities, "The fair, the right, and just thing in behalf of those persons with disabilities." That will be easy if we simply remember the persons with disabilities are for some of us a spouse, a child or other close relative. For others, a close friend or the friend of a friend, but they are always one of God's children for whom we have some moral and now a legal obligation to serve.

I would like to suggest some areas where I feel there should be labor management cooperation.

- Refer qualified job seekers with disabilities through their hiring halls or other referral systems, where they exist.
- Serve as liaisons between employers and special placement counselors from the state vocational rehabilitation agency or other specialized employment services organizations.
- Sensitize employers (and co-workers) to the benefits and desirability of hiring persons with disabilities.
- Jointly encourage outreach to community sources of job seekers who are disabled.
- Provide a buddy system to the new entrants to employment, i.e., assist qualified candidates in initial access to jobs (in addition to the return to work of disabled workers).
- Work with management to identify (current and future) jobs which are an appropriate match to the skills and limitations of persons with physical or mental disabilities.
- Promote the use of tax incentives available to employers of persons with disabilities under the Targeted Jobs Tax Credit (TJTC) program.
- Encourage and assist employers who have had good experience with workers with disabilities to communicate this information to other employers and to employer associations.

Unions can be a valuable resource to employers at the administrative and supervisory level regarding accommodations at the work site. Some areas will require negotiations with the union if one represents the workers of the company before changes can be implemented such as, job restructuring, task simplification, and work-site alterations.

ADA is merely an extension of the legal responsibility of unions and the role that they currently play as an advocate of all the members and particularly of workers with disabilities who are or who become members. It is the unions' duty and responsibility to:

- Assist the worker in accessing community services resources and public assistance programs (e.g., Social Security disability income support and medical assistance).
- Monitor and assist in resolving the problems of the returning disabled worker or the new disabled entrant.
- Work with management to ensure that workers with disabilities are paid wages commensurate with that of workers who are not disabled.
- Create a climate of acceptance of persons with disabilities among co-workers.
- Involve workers with disabilities in sensitizing coworkers, stewards, and business agents.
- Monitor employer compliance with affirmative action and non-discrimination obligations under federal and state laws.

There are some areas of the collective bargaining agreement where special contract language will be needed in order to implement the law. Some of these are in the areas of nondiscrimination; the retention, retraining or transfer of employees with disabilities; promotion and transfer clauses, to name only a few.

If language to address the issues is to be included in the collective bargaining agreement, union consent will be necessary.

A number of unions are already involved in providing rehabilitation services and have considerable experience already in that field, i.e.,

- International Association of Machinists Center for Administering Rehabilitation and Employment Services (IAM CARES), Washington, DC
- Human Resources Development Institute (HRDI) Handicapped Placement Program, Washington, DC
- American Federation of State, County, and Municipal Employees (AFSCME), New York City, NY
- Communication Workers of America (CWA), San Francisco, CA
- United Auto Workers (UAW), Detroit, MI. In cooperation with the Pontiac Division of General Motors
- The Amalgamated Clothing and Textile Workers Union (ACTWU), New York, NY
- Services Employees International Union (SEIU), Seattle, WA

Now I would like to highlight and perhaps focus upon some aspects of the new legislation, we should mention that the Americans with Disabilities Act contains five titles. However, I will discuss only Title I in this article.

- Title I Employment of the ADA specifies that an employer, employment agency, labor organization, or joint labor-management committee may not discriminate against any qualified individual with a disability in regard to any term, condition, or privilege of employment.

We should notice that persons with disabilities under this law should not be excluded from job opportunities unless they are actually unable to do the job. The requirement that job criteria actually measure skills required by the job is a critical protection. Discrimination occurs against persons with disabilities because of stereotypes, discomfort, misconceptions, and fears about increased costs and decreased productivity. The requirement that persons with disabilities not be disqualified because of the inability to perform nonessential or marginal functions of the job. The requirement that any selection criteria that will screen out or tend to screen out people with disabilities must be job-related and consistent with business necessity. There is a requirement to provide reasonable accommodations to assist persons with disabilities to meet legitimate job criteria. These requirements are designed to work together to eliminate the pervasive bias against employing persons with disabilities.

All entities, which include both employers and unions, should note the definition and the essential function of a job. The phrase "essential functions" means job tasks that are fundamental and not marginal. The point of including this phrase is to emphasize that employers can continue to require that all applicants and employees, including those with disabilities, be able to perform the essential, that is, nonmarginal, functions of the job in question.

The law does not prohibit an employer from devising physical and other critical tests for the job so long as the criteria is related. Employers need to provide job accommodation but they have the

right to select the least expensive accommodation so long as it is effective. In determining what is a reasonable accommodation as related to cost, the employers can only include *his cost*, only the portion which is *his cost*, the portion paid for by agencies or by the employee themselves can not be used to substantiate that the accommodation is too expensive.

Employers and unions alike must begin to modify their collective bargaining agreement to bring them into compliance with the law. Remembering that the law clearly states that a collective bargaining agreement or a contract or agreement with a referral source cannot be used as a defense for non-compliance with the law even though such agreements would prohibit compliance with ADA. In short, if there is a conflict between ADA and such agreements, ADA takes precedent.

On the plus side. The ADA does not require an employer to make any modification, adjustment, or change in a job description or policy that it can demonstrate would fundamentally alter the essential functions of the relevant job.

Undue hardship is a defense for non-compliance with ADA. The term "undue hardship" means an action requiring significant difficulty or expense, i.e., an action that is unduly costly, extensive, substantial, disruptive, or that will fundamentally alter the nature of the program.

The determination of undue hardship is a factual decision that must be made on a case-by-case basis. As in Section 504 of the Rehabilitation Act, the burden is on the employer to demonstrate that the needed accommodation would cause an undue hardship. Discrimination in employment does not only effect the relationship between the employer and the hiring of an employee, but additionally involves other employment related issues such as:

- Recruitment, advertising, and the processing of applications for employment.
- Hiring, updating, promotion, award of tenure, demotion, transfer, layoff, termination, right or return from layoff and hiring.
- Rates of pay or any other form of compensation and changes in compensation.
- Job assignments, job classifications, organizational structures, position descriptions, lines of progression, and seniority lists.
- Leaves of absence, sick leave, or any other leave.
- Fringe benefits available by virtue of employment, whether or not administered by the employer.
- Selection and financial support for training, including apprenticeship, professional meetings, conferences, and other related activities, and selection for leave of absence to pursue training.
- Employer sponsored activities, including social or recreational programs.

Both employers and unions might be well advised to develop policy statements on the above issues well in advance of any charge of discrimination being filed against them.

On the bright side for employers and unions but of some concern to those with disabilities is the simple fact that unless the regulations and case laws are developed to expand the act, employers do not appear to be obligated to prefer applicants with disabilities over other applicants on the basis of disability.

Under ADA, an employer could not enter into a contract for liability insurance with an insurance company who refused to cover accidents or injuries of person with disabilities. Nor could the employer refuse to hire a person with a disability because their liability policy did not cover disabled persons.

It will be interesting to see if and to what extent the law will allow insurance companies to deny insurance coverage to employees for a pre-existing condition.

In cases where an accommodation would present an undue hardship to an employer because of cost, the employer could not deny employment to a person with disabilities so long as the employee or an advocate of an employee or a public agency was willing to share the cost of such accommodation, thus preventing the claim of undue hardship based upon the cost factor alone.

There seems to be three pivotal provisions employers can use which summarize the fit between job criteria and an applicant's actual ability to do the job:

- The requirement that persons with disabilities not be disqualified because of the inability to perform nonessential functions of the job.
- The requirement that any selection criteria that screen out or tend to screen out be job-related and consistent with business necessity.
- The requirement to provide reasonable accommodation to assist disabled persons to meet legitimate criteria.

An interesting provision of the law which I am sure will be tested in the courts involve employment entrance medical examinations. There is a narrow exception to making medical inquiries that are not strictly job-related. That exception is, after an offer of employment has been made and only then can an employer require a medical examination.

It appears that with medical evidence, that a job which would do substantial harm to the applicant should he/she perform particular functions of the job could be denied unless there were ways to accommodate the applicant in ways to prevent such harm. Again, there are three points which might be worth considering in making such a determination:

- First, the assessment that there exists a high probability of substantial harm must be strictly based on valid medical analyses.
- Second, any determination by a company physician can be challenged by evidence from the complainant's physician. An employer is not shielded from liability merely by a statement from the employer's physician that a threat of imminent substantial harm exists.
- Finally, employment decisions cannot be based on paternalistic views about what is best for a person with a disability.

As might be expected, both unions and employers are concerned as to how the law will be applied regarding abusers of illegal drugs. The law as written permits an employer to deny employment to a person who currently uses illegal drugs.

However, a person who has successfully completed a drug rehabilitation program is protected by the law and cannot be discriminated against. Employers as a covered entity are also authorized, notwithstanding any other provision of the Americans with Disabilities Act:

- To prohibit the use of alcohol or illegal drugs at the workplace by all employees.
- To require that employees not be under the influence of alcohol or illegal drugs at the workplace.

- To require that employees conform their behavior to requirements established under the Drug-Free Workplace Act of 1988.
- To hold a drug user or alcoholic to the same qualification standards for employment or job performance and behavior to which it holds other individuals.
- To require employees in sensitive positions, as defined by the Department of Transportation regulations regarding alcohol and drug use, the Department of Defense drug-free workplace regulations, and the Nuclear Regulatory Commission regulations regarding alcohol and drug use, to comply with the standards established by such regulation.

The law clearly provides that the term "illegal drugs" does not include drugs taken under direction of a licensed health care professional.

In conclusion, a comment or two on the enforcement of ADA seems appropriate. The powers, remedies and procedures set forth in Section 705, 706, 707, 709, and 710 of the Civil Rights Act of 1964 are available to the EEOC, the Attorney General or to any other person alleging discrimination on the basis of disability in violation of any provisions or regulations of the ADA concerning employment. Thus, the powers, remedies and procedures available to persons discriminated against based on disability are the same as, and parallel to, the powers, remedies and procedures available to persons discriminated against due to their race, color, religion, sex or national origin. Any amendments to Title VII's provisions on remedies, etc., will also be fully applicable to the ADA as the law is now written.

I would project, based upon my experience that the regulations as developed will be modified and/or a substantial amount of case law will be accumulated developed as challenges to the law and individual acts of implementation are challenged by charges filed with the Equal Employment Opportunity Commission and eventually settled in the courts.

Acknowledgements

In addition to direct quotations in providing an overview to ADA, I have drawn extensively in my remarks from *CCH's Explanation of the Americans with Disabilities Act of 1990*, Commerce Clearing House, Inc., 4025 West Peterson Avenue, Chicago, Illinois 60646.

Some of the above material also draws heavily from the research document, *A Manual for Labor Organizations and Their Members & Rehabilitation Organizations Employment Specialists, Job Coaches, Rehabilitation Counselors, and Advocates*, by Claude W. Whitehead, produced by Employment Related Services Associates, 12317 Golden Oak Circle, Hudson, Florida 34669. Published and printed by Ralard Printers, Inc., 7700 State Road 52, Dade City, Florida 33525.

Seminar Recommendations

Vocational Rehabilitation

The following recommendations were predicated on the assumption that the focus of rehabilitation, including vocational rehabilitation, is on dignity and enhancement of the individual throughout the life span. All age groups should be able to receive needed services with attitudes which provide opportunities to achieve independence and a high quality of life. As such, the group affirms the uniqueness of the rehabilitation counseling model which offers the promise that services needed by older persons with disabilities will be delivered in a caring and efficient manner.

Service Delivery

There is a need to develop where lacking and to increase where in existence networks and relationships between vocational rehabilitation (Rehabilitation Services Administration [RSA], the state/federal system), groups concerned with aging (American Association of Retired Persons [AARP], etc.) and the private sector including labor unions with the objective of facilitating service delivery objectives.

There should be encouraged development of cooperative agreements between vocational rehabilitation (RSA, Council of State Administrators of Vocational Rehabilitation [CSAVR]), and groups such as the National State Units of Aging (NSUA).

The use of volunteers within vocational rehabilitation should be maximized especially of persons with disabilities who are older and can be seen as role models by others. An additional benefit in using volunteers is their ability to supplement the service delivery system.

The rehabilitation system should be viewed as a systematic or comprehensive one and more extensive use of this continuum may be necessary. Employment may or may not be the goal and services can be extended to include referral for independent living services under other parts of the Rehabilitation Act.

The vocational rehabilitation system should focus more of its emphasis and efforts toward the older workers with disabilities and develop innovative methods and techniques aimed at promoting independence, personal choice, and dignity for this population.

Program Development

Older persons with disabilities should be established as an RSA priority. Vocational rehabilitation should give greater emphasis to the older worker as part of its mission and will need to include:

- better training of counselors with regard to the older person;
- more creative use of jobs, scheduling (along the lines proposed by the Rupert paper on equiflex), and a review of current closure guidelines and outcome criteria to allow greater flexibility for reporting success;
- increased utilization of Title VII of the Rehabilitation Act (Independent Living) when Title I (Vocational Rehabilitation Services) is not appropriate so that an array of services or options are available to older persons;
- expansion of the Projects with Industry (PWI) program including the number of Projects that are specifically earmarked for older workers.

RSA and other advocacy groups should continue to present their needs and service priorities to appropriate legislative bodies. Changes should be sought with regard to the outcome criteria related to successful closure for vocational rehabilitation.

Training

Joint training activities should be promoted between vocational rehabilitation and other groups and organizations interested in the older population to enhance the services provided for older persons with disabilities. The active participation of older persons in the development of these activities is strongly encouraged.

Staff within vocational rehabilitation should have adequate training in the process of aging, positive attitudes regarding aging, and a general understanding of older persons.

RSA priorities for Short Term Training should include a focus on aging.

Long Term Training programs should be initiated which encourage integration of gerontology, independent living, and rehabilitation counseling.

Joint training endeavors should be encouraged between business/industry/labor, vocational rehabilitation, and groups/organizations interested in older persons to better prepare older persons for workforce participation.

Research

Specific areas needing research include the role and impact of family, cultural/ethnic/racial, and cohort variables on the rehabilitation of the older person. In addition, there is a need for further research to explore the diversity and individual talents that older persons bring to the workplace and society.

Research projects should target populations with specific needs. Some racial/ethnic groups have higher incidences of specific disabilities and yet very little is known whether services have been or are available (e.g. migrant workers).

The National Institute for Disability and Rehabilitation Research should earmark funds to study the impact of study groups such as the Switzer Seminar on the rehabilitation system.

Cooperative cross/interdepartmental research efforts should be expanded among organizations, federal agencies, and rehabilitation specific to productivity and older persons.

Research efforts in vocational rehabilitation should be developed that examine the use of various rehabilitation counseling models and the enhancement of independence and/or productivity of older persons.

Legislative

Articulate priority for projects related to older persons including expansion of legislative authority in all parts of the Rehabilitation Act.

Earmark discretionary funds for service delivery to older persons during legislative hearings.

Change and expand funds under Title VII (Independent Living) from discretionary to a formula grant system so that all states will have program. Create a new section under Title VII to expand to all disabilities the older persons served through a formula grant process.

Increase number of Projects with Industry programs specifically earmarked for older persons.

Tie in or coordinate the Older Americans Act to enhance independence of older persons.

Consider aging alone as an eligibility criteria for vocational rehabilitation services.

Provide for adequate funding for research, training, and program development related to older persons.

Other

Allocate position(s) for specialist(s) within Rehabilitation Services Administration and state vocational rehabilitation agencies for older persons with disabilities.

The vocational rehabilitation system including RSA should work with appropriate congressional and oversight committees in a coordinated effort with other advocacy groups such as AARP, CSAVR, NRA, and union groups toward achieving service, research, and program development objectives for older persons with disabilities.

Employer Flexibility

Service Delivery

Educate older workers with disabilities on the advantages of flexible work options and train them to successfully negotiate their inclusion in the workforce. Educators would include, nonexclusively, state and regional trade unions, community-based councils, vocational rehabilitation, projects with industry, and other older worker service constituent organizations (e.g., AARP, NRA).

Policy or Program Development

Organizations develop and implement human resource policies and procedures to address flexible scheduling needs, prorated benefit packages, and dependent care issues of individual workers.

Training

Information should be provided to older and disabled workers about the range and potential value of flexible work options that could be made available to them. This would include practical suggestions for negotiating these options with the employer.

Educate employers and union representatives on the range and value of flexible work options. Train managers, supervisors, and shop stewards to set up flexible work programs. Materials and training procedures should be developed with the assistance of the federal government.

Create effective print and video training materials to educate employers, providers, consumers, and all interested parties about workplace flexibility. Funding should come from the Department of Labor, national foundations, national organizations and progressive businesses and unions.

Research

Initial survey of what employers are doing? Re: flexible work options for employees (employers size, type, category, kinds of flex options available, degree of usage policies and procedures, contact persons).

Study of cost effectiveness and productivity implications of flexible work options in small, medium and large organizations.

Study to determine employer utilization and motivation to use contingent workers.

Legislation

Congress shall mandate and fund and the Bureau of Labor Statistics shall implement a revised data collection system that will accurately record characteristics and conditions of the part-time, temporary and independently contracted labor force so that effective policy may be planned and developed.

To enable employers to offer fair and flexible work options, to reduce the national health care budget, and to provide for the health and well-being of all workers, including specifically, older workers with disabilities, the U.S. Congress should adopt a national health insurance system.

Health Care Needs

Three themes were repeated in each of the five categories:

- The need for national health insurance;
- Health care needs and rehabilitation should be considered together, on a continuum, and not as two different things;
- The employer and the employee must establish a partnership in any work/disability situation.

Programs and Policy

Establish a statement of policy that develops a system that is... individually based, employer driven, government

guided, advocacy tuned, rehabilitation and health care supported.

Establish viable national health insurance that provides access to high quality health care.

As a possible first step, not as a substitute, establish a high-risk pool for coverage. This would make coverage available to those who are unable to purchase insurance because of high-risk status.

Establish a basi' set of expectations for post-retiree health benefits looking toward setting a policy based on research.

Establish a policy that would provide affirmative benefits for healthy employee behavior— non-smoking, exercise, etc.

Establish a policy that rewards continuity— services are provided along a continuum of ages and needs rather than agency by agency.

Service Delivery

The rehabilitation service delivery mechanism should be integrated with the health care mechanism. This should include, as a matter of course, non-work related disabilities and children's needs. (Note: physicians need to be trained that the rehabilitation service delivery piece exists.)

At the employer level, promote communication with management personnel, worker's compensation personnel and the individual with the disability.

Promote timely early intervention.

Promote earlier eligibility for entrance to the disability insurance system for early action and response.

Promote case management as integral part of rehabilitation and health care.

Provide options for types of case management based on what the employee and the employer need— self-directed, employer-based, externally run.

As part of an individual's integratec rehabilitation and health care plan, types and levels of responsibility for "players' should be delineated e.g. worker/entrant, employer or supervisor, government agency, health care system, attorney, insurance carrier, union.

Research

Develop and examine models that integrate vocational rehabilitation, health care and worker's compensation to determine the most effective model for addressing the needs of the aging workforce.

Research designs for programs that respond to the diverse needs of the aging population—moving out of the workforce— geriatric rehab.

Design and conduct research that examines the costs and benefits of providing post-retiree health benefits. The results would drive a policy statement.

Examine the costs and benefits of promoting workforce retention— does productivity have to be defined as staying in the workforce?

Design and research a funding mechanism for a national program of personal assistance services.

Trainıng

Establish programs to train physicians and health care providers about: availability of rehabilitation services; implications of chronic disability in an aging population; positive results of early intervention.

Establish programs to train individuals to be their own advocate.

Establish programs to train employers about the cost benefits of planned early intervention and rehabilitation, as well as the implications of not utilizing health care and rehabilitation services.

Establish core areas in aging and rehabilitation in professional curricula for health care/rehabilitation professionals.

These programs should be offered as both in-service and preservice.

Legislation

Establish national guidance for promoting consistence in state programs such as worker's compensation.

Legislate national health insurance.

To begin, legislate a high-risk pool.

Within the Social Security law, make legislative or regulatory changes to: change nine-month SGA (Successful Gainful Activity) requirement for successful rehabilitation reimbursement to match the Dept. of Ed. two-month requirement; and, change SGA to $700 for all SSDI (Social Security Disability Insurance) beneficiaries.

Legislate personal assistant service services.

Attitudes/Legal Issues

Service Delivery

It is recommended that people who are older and disabled be encouraged to play a more assertive role in their own medical and human service care by challenging traditional methods of delivery of health and service to assure their participation in ensuring the high quality of those services.

Also encouraged is an assertive rather than a passive approach to being a patient or client, being in control rather than being dependent, and using a self help model.

It is also recommended that human service professionals exercise rapid response in interventions so as to begin assistance to people with a disability as soon after the onset or occurrence as possible.

It is recommended that more and better low vision services be provided to people who are older and who need them.

Policy or Program Development

It is recommended that methods be developed to upgrade the State-Federal vocational rehabilitation program to put more emphasis on providing sustainable employment and encouraging enhancement of the careers of people with disabilities. (e.g. provision of post-employment services when needed, updated equipment when needed, facilitated and more prompt service).

It is recommended that disability awareness be incorporated into all education systems, public and private at all levels (K-12). It is recommended that the interpersonal issues be addressed as well as those which are potentially personal, to prepare students for their own possibly disabling injury or disease. Backdrop for this training should be the understanding

that disability is a natural occurrence of the human condition.

Training

It is recommended that public and private employers and public and private service providers be encouraged to become aware of the disabling conditions of and the capabilities of employees as they become older. It is further recommended that the body of literature on aging be made available to employers and service providers and that they be able and willing to make accommodations for workers who are older.

It is recommended that public and private employers and the general public be educated about prevention of injury, disease and other causes of disability.

It is recommended that service providers to people who are older and disabled draw from the body of knowledge of the independent living movement as they plan programs (e.g. perception of disability; dealing with community-based services, including health care; attitudes; and advocacy).

Research

It is recommended that methods be developed to identify, conduct and disseminate research about the productivity of workers who are older.

It is recommended that research be conducted to determine to what extent "health conditions" play a role in people's departure from the work force. Also, to what extent do the human services, social services and health service systems plan a role in supporting premature departure (e.g. health insurance, workers' compensation, public rehabilitation systems, social security disability insurance).

It is recommended that assistive technology (from low to highly technical devices) be developed and provided which are user friendly to support people with sensory and other disabilities who are older. It is further recommended that methods be discovered to help combat the resistance which some people who are older have to using assistive technology.

Legislation

It is recommended that public and private employers be separated from health insurance responsibility.

It is recommended that "Retirement" be redefined in our society. Incentives to working longer should be explored, such as: short term project employment, tax credits and deductions, desirable benefits, options for extended work life. All options should be based on personal choice. Perhaps the greatest work incentive would be the elimination of the limit on earnings which people on social security can receive. Other disincentives should also be eliminated.

Other

It is recommended that public and private employers be informed about community services to assist older employees with disabilities. It is also recommended that employers be educated to the realization that hiring people with disabilities who are older can be to their benefit.

It is recommended that coalitions and networks among employers be built which are community based to share strategies and services of older workers with disabilities. Model programs, such as the Job Accommodation Network (JAN) in West Virginia, should be publicized. JAN, a database that supplies information about employing people with disabilities and about availability of equipment for people with disabilities, suggests approaches that employers can use in disability management [for information, call (800) 526-1234].

National Rehabilitation Association

Officers

Harry R. Smith
President
Lansing, Michigan

J. Larry Johnson
President-Elect
Montgomery, Alabama

Bill Brownfield
Past President
Reston, Virginia

Jerry Bensman
Treasurer
Atlanta, Georgia

Board Members at-Large

Susan G. Sherman
Atlanta, Georgia

James B. Adams
Paducah, Kentucky

James Searcy
Montgomery, Alabama

Robbi Blackburn
Waynesboro, Virginia

Tommy Allen
Winston-Salem, North Carolina

S. Wayne Mulkey
Knoxville, Tennessee

Council Representatives

NCMRC

Joyce M. Keener
Detroit, Michigan

CDP

John Chappell
Boston, Massachusetts

CCP

J. Thomas Cobb
Rome, Georgia

Regional Representatives

Great Lakes

James S. Buscetta
Southfield, Michigan

Pacific

Amos Sales
Tucson, Arizona

Great Plains

Kenneth L. Bosch
Boulder, Colorado

Mid-Atlantic

Frances Salbeck
Joppa, Maryland

Northeast

Nancy Dumart
Ashland, Massachusetts

Southeast

James Turner, Decatur, Georgia

Southwest

Vince Bond
Little Rock, Arkansas

Division Representatives

NARI

Janet C. Simmons
Fisherville, Virginia

NARS

Delores H. Spires
West Columbia, South Carolina

NRCA

Faith S. Kirk
Rockville, Maryland

VEWAA

Doug Seiler
Fargo, North Dakota

JPD

Marvin Tessman
Ankeny, Iowa

NASPPR

Carolyn B. Thompson
Frankfort, Illinois

NAIL

James De Jong
Springfield, Illinois

NRAA

Kathy Williams
Frankfort, Kentucky

National Staff

Ann Ward Tourigny, Ph.D., CAE
Executive Director

Norma Maxson
Director of Office Operations

Mark W. Doyon
Director of Communications

Bill Brownfield
Director of Chapter and Training Services

Anne Marie O'Keefe
Governmental Affairs Counsel

Ann Martino
Systems Operator

Veronica Hamilton
Membership Services Specialist

The Mary E. Switzer Memorial Committee

Carl E. Hansen, Ed. D., Chairperson, University of Texas, Austin, Texas
Prof. Bertram J. Black, Albert Einstein College of Medicine, New York
Karel Disponett, Residential Services, Seven Counties Services, Inc., Louisville, Kentucky
Susan Suter, Director of Public Welfare, Springfield, Illinois
Richard Switzer, Deputy Commissioner, New York Office of Vocational Rehabilitation, Albany, New York

Ex Officio Members

Harry R. Smith, President, National Rehabilitation Association
Robert E. Brabham, Ph.D., Past Executive Director, National Rehabilitation Association
Leonard G. Perlman, Ed.D., Coordinator, Switzer Memorial Seminars

Leonard G. Perlman, Switzer Seminar Coordinator, Richard Materson, M.D., Medical Director, NRH, and Carl E. Hansen, Switzer Committee Chairperson.

Switzer Scholar Thomas Fleming.

1991 Switzer

Carl E. Hansen and Representative Peter J. Visclosky (D-IN), U.S. House of Representatives.

Former Switzer Scholars Dick Melia, James R. Burress and Fred Sachs.

Seminar

Colleagues of the late Mary Switzer. Back row: Carl E. Hansen, Fred Sachs, James R. Burress, Thomas Fleming, and Dick Melia. Front row: Leonard G. Perlman, Miriam Stubbs and Thelma Schmones.

Doris Margolis, Carl E. Hansen and Switzer Scholar Paul Leung.

Switzer Scholar Richard Oestreich and Carl E. Hansen.

Switzer Scholars John R. Nelson, Judy Ann Buffmire and Richard Coelho.

Making the Life That's Saved Worth Living

Each year, the lives of thousands of people in this country are saved by advances in medical knowledge and technology. Many of those who are saved are permanently disabled. They can't walk, talk, drive, or even get around in their own homes.

At the National Rehabilitation Hospital in northwest Washington, D.C., we help people learn to help themselves. Through specialized medical care, therapy, and other services, we focus on abilities rather than *dis*abilities. Our goal is to enable people to be as active and independent as possible.

At NRH—one of the top medical rehabilitation hospitals in the nation—we offer inpatient and outpatient services for adults and adolescents with disabilities from stroke, head or spinal cord injury, amputation, arthritis, chronic pain, post-polio syndrome, and other conditions.

NRH
NATIONAL REHABILITATION HOSPITAL

To find out more, contact the NRH Admissions Office, 102 Irving St., NW, Washington, DC 20010-2949; (202) 877-1152.

National Rehabilitation Hospital
"Adding Life to Years"

A not for profit member of the Medlantic Healthcare Group

Mary E. Switzer

1900-1971

Few people realize that Mary E. Switzer had a satisfying and fully successful career in federal government employment that spanned several decades prior to her formal entry into the field of rehabilitation. She was fifty years old when she became director of the Office of Vocational Rehabilitation in 1950, and she brought to the position a superior intellect and ability. Her many talents and experiences in economics, the legislative process, government administration, health, welfare and public education were only a few of the composite assets brought with her. She entered the movement at a crucial point in its evolution. It was a time in which difficult decisions had to be made between maintaining the status quo or moving to a larger and unknown future, but with increased opportunity to serve tens of thousands of people with disabilities yet in need.

Following a life pattern in support of increased services to people with a more responsive and humanitarian government to changing human needs, she readily committed herself to the less certain but more hopefully expanded future for rehabilitation. The rest is history. The breadth and humanity of Mary Switzer are stamped forever on the passage of *Public Law 565* with its research and demonstration features, its concern for rehabilitation education, its mandate to construct necessary rehabilitation facilities, its totally new characteristic of international efforts and cooperation regarding rehabilitation, and perhaps, above all, in its expanded funding base for more personnel and programs for those in need of rehabilitation services. In the years that followed, she went on to even greater legislative and governmental leadership heights on behalf of both disabled and disadvantaged people.

Despite the demands on the national and federal scene, her presence was almost ubiquitous on behalf of program development and extended services to needy people. On a regional, state or local level, be it public or voluntary services, if it were in the interest of rehabilitating those in need, somehow, she would "arrange to be there."

The *Who's Who* has chronicled her many national and international awards. Also recorded are her presidencies of many organizations including the National Rehabilitation Association, whose members and their efforts she held in high esteem. But she did not reach the heights of her ability when she was made the first Administrator of the Social Rehabiliation Services, nor when she retired from the position, nor when she became internationally involved in the World Rehabilitation Fund. Instead, she found her greatness when she touched each of us, bringing our full humanitarian efforts and qualities to the fore on behalf of disabled and disadvantaged people. While readily recognized as a truly great administrator in the classical sense, her true capacity and ability can only be appreciated when we realize that these accomplishments sprang from an inner expression of sensitivity, emotional refinement and dedication to serve all less fortunate people. Her egalitarian qualities were not contrived but spontaneous, stemming from love and respect for all living things.

All of us in the National Rehabilitation Association and in rehabilitation, and all people with disabilities, have had better, more meaningful and more productive lives because her presence and her being were sufficiently large to embrace and accept us as we are and help us better understand where we should be.

What more can be said than that we had the joy and privilege of knowing her?

—E.B. Whitten, *Journal of Rehabilitation*, November/December, 1971.

BEST COPY AVAILABLE

Switzer Memorial Seminars

As a living tribute to the memory of Mary E. Switzer, each year a special topic of vital interest to the rehabilitation of persons with disabilities is explored in depth. One of the outcomes of each seminar is a *Switzer Monograph* which clarifies the thinking in a given area of rehabilitation and sets goals and objectives for positive action. Those individuals invited to participate in the Seminar are designated as Switzer Scholars.

Mary E. Switzer Memorial Seminar and Monograph

To perpetuate the memory of a great woman and a great leader in the field of rehabilitation by establishing a memorial that will expand and enrich services to persons with disabilities.

National Rehabilitation Association
1910 Association Drive, Suite 205
Reston, Virginia 22091

BEST COPY AVAILABLE